MENTAL HYGIENE

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THOMAS WILLIAM SALMON

(1876–1927)

THE death of Dr. Thomas W. Salmon on August 13th deprived the cause of mental hygiene and psychiatry of a leader of remarkable influence and usefulness. During a brief span of life, he made a contribution of inestimable value to the advancement of mental hygiene and to the extension of psychiatry into a broader field. As the first medical director of The National Committee for Mental Hygiene, he gave form and vitality to its activities and established it in the confidence of the medical profession and the public. By his distinguished services in organizing and administering a neuropsychiatric department in the medical corps of the army, and by the striking demonstration of its value during the World War, the place of mental hygiene and psychiatry was still further advanced. More recently he was instrumental in accomplishing a notable advancement in the provision for psychiatry in medical education and research, and he occupied an outstanding position in the educational field, in private psychiatric practice, and as a guide, counselor, and friend to innumerable workers in mental hygiene.

Dr. Salmon was born in Lansingburg, New York, January 6, 1876. His father, Dr. Thomas H. Salmon, and his mother, were natives of Stratford-on-Avon, England, where the family had long resided. One of his ancestors was a teacher in the grammar school at which Shakespeare was once a pupil, and was also the custodian of the Shakespeare house. One of Dr. Salmon's boyhood recollections was of a summer that he spent in Stratford with his father. He received his early education in the public schools and graduated from the

Lansingburg Academy. He then taught school for about two years. His medical course was taken at the Albany Medical College, from which he received his degree in 1899. The qualities that later distinguished him were early manifested. He was much respected and was once nominated as a candidate for election to the state assembly.

Soon after his graduation he entered into private practice at Brewster, New York. After spending two years there, he was advised to discontinue because of illness and to spend some time in the Adirondacks. He soon recovered and, in the fall of 1901, he accepted a temporary position at the Willard State Hospital. The prevalence of diphtheria at this large institution furnished him with an opportunity to observe the rôle of infected well persons in the transmission of the disease. His careful and extensive study of carriers was amongst the earliest recorded. It was included in a report of the epidemic that was incorporated in the annual report of the State Commission in Lunacy for 1904, and was, in consequence, not widely circulated. He was not at that time inclined to a career in psychiatry and, in 1903, he accepted a commission in the United States Public Health Service. He was at first assigned to the general hospitals of the service, and became much interested in the sailors who were patients there. He advocated a hospital ship for the deep-sea fishermen and submitted plans for its construction. Ever afterwards the sea had a fascination for him and as soon as circumstances permitted, he adopted yachting as his principal recreation.

His most notable achievement in the Public Health Service was the establishment of a psychiatric service for immigrants on Ellis Island. He was assigned to the immigration service in 1905. At that time no provision was made for protecting the country from the admission of insane and defective immigrants, or for furnishing adequate treatment at the ports of landing for cases whose condition compelled attention. The state of New York, aroused by the disproportion of aliens among the admissions to the state hospitals, had recently established a board of alienists and had requested that they be permitted to aid in the examination of the immigrants arriving at Ellis Island. The necessity of this was not

apparent to the immigration authorities, but it was thought advisable to pay some attention to the subject, and Dr. Salmon was assigned to the task. It was not long before the number of cases discovered became so large that he recommended the employment of a group of specially qualified physicians for the work. He endeavored also to secure better treatment for the cases requiring it. He met with great difficulties, and displayed the strength and resources that later enabled him in a broader field to accomplish so much. Eventually, he was furnished with assistants, and a psychiatric service was established as an essential department of the medical organization at Ellis Island. He drew plans for a special hospital building where cases could be given proper treatment and this was erected. What he accomplished at Ellis Island was of enormous benefit in protecting the country from the influx of insane and defective immigrants and in raising the standards of the immigration service to a more humane and scientific level. He contributed to the advancement of other departments of the medical service on Ellis Island, especially those that had to do with children, and drew the sketch plans for a hospital for contagious diseases which was afterwards erected. His observations and views, especially with reference to the relation of immigration to insanity and crime, were much respected. He wrote a number of articles on the subject, and when revisions of the law were pending, he was invited to appear before committees of the Congress and before the President and many of his admirable recommendations are now incorporated in the law. In 1911, he was, at the request of the New York State Commission in Lunacy, given leave of absence in order to serve as chief medical examiner of the Board of Alienists. During that year he coöperated with the statistician of the commission in planning a study of foreign-born patients in the state hospitals. He had previously been of assistance to the commission in shaping broad statistical studies as, in 1908, he had taken part in establishing the system of statistical records that is now in operation in the state hospital service. The first graphic charts of medical statistics that were published by the commission were prepared by him. Later, when medical director of The National Committee for

Mental Hygiene, he was instrumental in having a similar system approved by the American Psychiatric Association for introduction into all the hospitals for mental disorders, thus making possible nationwide studies by the National Committee and the United States Census Bureau.

In 1912 he was engaged by The National Committee for Mental Hygiene as director of special studies. This committee, though founded in 1909, had previously, owing to lack of funds, been unable to take up active work. Under Dr. Salmon's direction, a survey of the hospitals and other agencies and of methods employed in dealing with mental disorders was undertaken. The conditions that were disclosed and the opportunity for a work of great significance and importance made a strong appeal to him. He resigned from the Public Health Service and, when the work of the National Committee had been sufficiently advanced, he was, in 1915, appointed medical director. The survey opened the way to various avenues of usefulness, and, as funds were obtained, the organization was developed and new lines of activity were undertaken. When he resigned from the position on January 1, 1922, the work had so greatly extended that it was carried on under seven divisions and the budget for the ensuing year was $180,000. In the special committees under which the several divisions operated were men who were leaders in the various fields that come within the scope of mental hygiene, and the directors of the divisions were capable and experienced. He was, however, accepted by all as the master mind and all found in him an unfailing source of information, wise guidance, and inspiration. His experience in the federal and state services and his acquaintance with public officials and departmental problems and methods aided him to think and act on broad lines. Notwithstanding the extent and character of his interests and activities, however, he never lost the viewpoint of the physician with relation to the sick man. This furnished him with a measure with which he almost automatically evaluated every situation and undertaking. It enabled him to see simply and clearly the lines that led most surely to the relief of the individual sufferer and to the conquest of disease and misery. He was genuinely modest in

regard to his own place in the work. Almost every important form of activity that the committee has engaged in was started by him. In every division he was constantly contributing something of value. One of the secrets of his strength and success was, however, the extent to which he was able to quicken and set in operation forces and activities that would continue without his assistance. His personal accomplishments and influence with large interests and with individuals were very great. In the federal and state government services, in private organizations and institutions of various kinds, in the fields of education, criminology, public health, and social welfare, may be found many officials and private individuals who acknowledge their indebtedness to him for valuable advice, practical assistance, and inspiration in the advancement of mental-hygiene aims and projects. He made many addresses, wrote numerous articles and important reports and outlines, and took part in many conferences that contributed greatly to the spreading abroad of mental-hygiene knowledge and to broadening the field of psychiatry. His interest in the individual sufferer led him to have a list made of physicians in every state who had experience or special qualifications in nervous and mental disorders. The purpose of this was to furnish a means of directing inquirers who applied to the committee, of whom there were many, to the nearest adviser. This list was of great value when it became necessary to enroll the qualified physicians of the country in the psychiatric service of the army.

To Dr. Salmon himself, the service he rendered during the war and afterwards for the relief of mentally disabled ex-service men seemed to be his crowning achievement. It was undoubtedly due to his sagacity and foresight that it was possible to organize promptly an adequate neuropsychiatric service in the army. Early in 1917 he, with Dr. Pearce Bailey and Dr. Stewart Paton, as a committee of the National Committee, presented the Surgeons General of the Army and the Navy a plan for the organization of neuropsychiatric units and for the early treatment and prevention of mental disorders in the military services and the elimination of mentally disordered recruits. In March, this committee, at the request of the

Surgeon General of the Army, made a study of the neuropsychiatric problems presented by the troops that were at that time mobilized on the Mexican border. In May, Dr. Salmon made a trip to Europe and collected extremely useful information in regard to the experience and methods of the allied nations already engaged in the war. When the time for action arrived, therefore, information was available that permitted of the prompt enrollment of the necessary medical and nursing personnel and the organization of the neuropsychiatric service required. Dr. Salmon accompanied the A. E. F. to France, with the rank of major and senior consultant in neuropsychiatry. Special base and advanced hospitals were established, and field psychiatrists were attached to all divisions of the army. The value of this service in eliminating mentally unfit recruits, in preserving morale and preventing nervous disorders at the front, and in providing adequate treatment for cases that required it, is one of the outstanding experiences of the war. Dr. Salmon was advanced to the rank of colonel, and when he was retired, was awarded the Distinguished Service medal and placed on the reserve list with the rank of brigadier general. His remarkable wisdom and resourcefulness were so manifest in the military service that, at headquarters in France, he was called "the judge" and was constantly consulted by the heads of the other departments of the medical service.

Upon his return to his position with the National Committee, he set himself to the task of securing adequate treatment for the mentally disabled ex-service men. He felt that in the further efforts to advance mental hygiene and psychiatry, the lessons of the war, and the aroused interest and knowledge that had been accomplished by the demonstration that had been made, should be taken advantage of. He endeavored to secure for the ex-service men model hospitals that would furnish a standard for all further developments throughout the country. A committee of psychiatrists who were experts on hospitals was called to prepare a model plan, and this was presented to the federal authorities and also published for general distribution. Strong efforts were required to secure the necessary appropriations, locate the hospitals advantageously, and de-

velop the plans and organization along the lines laid out. His sound and extensive knowledge, his convincing clearness and earnestness, and his remarkable resourcefulness in advising and planning, contributed probably more than anything else to the adoption of the liberal program of hospital provision that was eventually undertaken. When this task was accomplished, he felt free to resign from the position of medical director of the National Committee and resume the more direct relationship of physician and patient in which he had always found his greatest satisfaction.

In 1921, he accepted an appointment as professor of psychiatry at Columbia University. He extended the psychiatric department and established it on an independent footing. He was instrumental in securing for the new Medical Center at Columbia the State Psychiatric Institute and Hospital. This was a step of supreme importance in the provision for psychiatric education and research in America. He continued to be consulted from far and near by public and private officials, mental-hygiene and welfare workers, and a host of others who were interested in mental-hygiene problems. Notwithstanding the demands made upon him by his college work and private practice, his influence and power as a leader remained unimpaired.

Dr. Salmon was an unusually interesting and convincing speaker and made many addresses. He wrote and published numerous articles on mental hygiene and psychiatric topics. He was one of the founders and a member of the first editorial board of the magazine *Mental Hygiene*. He was the author of the chapter on immigration in *Modern Treatment of Nervous and Mental Diseases* (White and Jelliffe, 1913) and of the chapter *Prevention of Mental Disease* in *Preventive Medicine and Hygiene* (Rosenau, 1916). He also wrote the chapters on mental hygiene in the *American Year Book* (1917–1920) and he was editor of the volume on neuropsychiatry of the *Medical History of the World War*. He was a member of the leading national and New York societies of neurology and psychiatry as well as of the American Medical Association, the Association of Military Surgeons, and the New York Academy of Medicine. He was honored by his colleagues by election as

president of the American Psychiatric Association and of the New York Psychiatrical Society.

In his personal life he was simple and unaffected. He lived modestly and enjoyed the solid satisfactions of life. He spoke with humorous self-depreciation of the eminent position he had reached and was entirely without envy or gnawing ambition for advancement. He was fond of social life and simple pleasures, but was too fully occupied with his work and his home to be able to engage in sports or many diversions. During recent years he found rest and pleasure in cruising in his yacht. He was a member of the Larchmont Club, of the Century Club of New York, and of the Army and Navy Club of Washington. In 1899, he was married to Helen Potter Ashley. She was of a spirit similar to his own and was his strong support and helpmate in his ideals and aims. Six children were born to them, all of whom, as well as Mrs. Salmon, survive.

Dr. Salmon possessed personal qualities that a brief sketch of his life and career can scarcely portray. It was these as well as—perhaps more than—his great achievements that won for him the extraordinarily warm esteem in which he was held by so many. Few men have been more beloved in their life or more sincerely mourned at their death. It can be truly said of him that he was "gentle of speech, beneficent of mind". With this, however, he was also brave, prudent, wise, chivalrous, and on occasion bold and militant. He had, in fact, the qualities that have been termed knightly and was, indeed, "a verray parfit, gentil knyght".

WALTER BELKNAP JAMES

(1858–1927)

DR. WALTER BELKNAP JAMES has been likened to the country general practitioner, the old-time trusted family physician whose qualities of mind and heart—wisdom, tolerance, and love for his fellow men—endeared him to the whole community in which he served. This rapidly passing figure in our national life, the country doctor, is often apt to be the head of the local school board, the village or county health officer, director in the county bank, vestryman in the church and, far more important, friend and adviser in time of need to nearly every man, woman, and child in the county in which he practices.

In Dr. James, born and bred in the city, part of the city life in every respect, New York had just such a country general practitioner. His place in medicine will be described in memorial notices by those who knew him as a skilled clinician, far-seeing student of diseases and patients, and trusted counselor in desperate illness, but it was his unique privilege to serve in many of the affairs of state and city, like the vigorous practitioner in his county and village. He served the state officially as chairman of its Board of Charities, as member of the Hospital Development Commission, as first chairman of the State Commission for Mental Defectives, and in a number of other official and unofficial capacities. He served his city as president of the Academy of Medicine, as visiting physician to the Presbyterian Hospital, Bellevue Hospital, and the Hospital for the Ruptured and Crippled, as professor at the College of Physicians and Surgeons, and as trustee of Columbia University, and he had formal and informal connections with numerous other organizations—medical, scientific, philanthropic, social, and cultural. Other journals will tell of his great service to medicine, of his eminence as a teacher of medical students, of his wide influence upon the medical progress of his time and community, of his part in the planning and developing of that monumental enterprise, the great new

Medical Center, now under construction in New York City. It is the purpose of this journal to discuss only his contributions to that department of medicine which deals with the treatment and prevention of mental and nervous disorders.

It is significant that Dr. James, whose specialty was internal medicine and who devoted most of his professional life to the study and treatment of physical disorders, should have become deeply interested in neuropsychiatry at an age when most men add no fresh lines of knowledge to their accustomed ones and take up no new intellectual activities. It explains, in part, the unusual span of his productive years—measured no less by the importance of the latter phases of his career than by that of the former. Dr. James was, in a sense, a pioneer in that he was one of only a handful of physicians working in general medicine who turned their attention to the great problem of mental disease, the large majority of general practitioners being still preoccupied with the study and treatment of bodily ills.

Dr. James's first contact with the field of mental hygiene came in 1917, with his appointment to the Hospital Development Commission, which was created to deal with the problem of adequate institutional provision for the insane in New York State. He was selected to represent general medicine in the deliberations of this body, but he soon immersed himself in its studies, becoming as interested as any psychiatrist in the problem and giving generously of his time and energy to its work. The problem was an acute one. Overcrowding in the state hospitals had assumed the most serious proportions in the history of the state up to that time, and the most intelligent planning and wisest action were needed to meet the emergency. The increase in the number of mental patients had so far outstripped the provision made by the state for their housing and treatment that at the time the commission took up its work, the hospitals held nearly 25 per cent more patients than they could really accommodate and properly care for. While the population of the state had increased in the ratio of seven to ten within a period of twenty years, the number of inmates of the state hospitals had nearly doubled. It was the task of the commission to relieve the immediate urgency and to provide

a continuing program of hospital construction to meet the needs of the situation progressively for the next ten years.

Dr. James visited all the leading psychopathic hospitals of the country, investigating existing facilities and methods and studying the problems of care and treatment from every angle. Appreciating the great importance of research, Dr. James introduced the idea of diagnostic clinics in the state-hospital system, and strongly advocated the establishment of a new psychiatric institute, with adequate facilities for teaching and research. His services to the commission were invaluable. He lifted its work out of the usual rut of a legislative committee, putting the whole problem of the care of the insane on a high medical level and contributing not a little to the liberation of the state-hospital system from political influence. To a sound business judgment and administrative tact were added a patience and discretion that brought him a mass of data from state officials not easily accessible. He was tireless in his work, his enthusiasm and industry spurring every one else to effort, his unfailing optimism making a task that might otherwise have been distasteful a pleasant and hopeful one, and his engaging personality binding the whole commission together in delightful companionship. His close application to the task in hand led him, characteristically, to set up in his residence, in a small room adjoining his library, a drafting table with the full equipment of an architect. Here he personally made the original sketch drawings for a number of institutions and clinics that were later developed. His ideas were all incorporated in the reports of the commission, and one of its members did not hesitate to say that had its recommendations been carried out, he believed many of the problems connected with the care of the insane that are so troublesome to-day would have been solved in a satisfactory manner. As it was, Dr. James's work had not a little to do with awakening the public conscience to the plight of the mentally afflicted and paving the way for the $50,000,000 bond issue subsequently voted by the people of New York State for their care.

It was natural that Dr. James's work on the Hospital Development Commission should attract the attention of The National Committee for Mental Hygiene, which soon elected him

a member in recognition of his services. One of his outstanding services at this time (1917–1918) was in connection with the now memorable study of the psychopathology of crime made by the National Committee at Sing Sing Prison. Dr. James was a most active member of the advisory committee that sponsored this study. The conviction had been steadily growing among penologists and psychiatrists that the problems of both had a great many points of contact, the most obvious of which was the intimate association, so often plainly visible, between criminal activities and mental abnormality. The interrelation of the two groups, however, had not yet been scientifically studied, so that there were lacking the necessary data upon which to construct a program for the development of more radical and effective methods of dealing with delinquents before, during, and after imprisonment. This study did much to supply such data and had far-reaching consequences. The most important result was the construction of a psychiatric clinic for the intensive examination and study of the individual delinquent. This clinic has become, in fact, a central feature in the reorganization of Sing Sing Prison that has taken place in the last decade. Dr. James was quick to see the medical implications of habitual crime and as a true physician he looked upon the problem as one analogous, in a sense, to the problem of disease, requiring intelligent diagnosis and treatment. His convictions on the subject are accurately reflected in the following statement which he made to the governor of New York State at the time of the study:

"I cannot help feeling that this would be an excellent thing. There can be no doubt of its absolute necessity. Psychiatry has come to stay, and has come to occupy a larger and larger part in the collective affairs of society. Every day in my own practice I meet conditions which recall similar problems met with in earlier days, unsatisfactorily solved then, and leaving me now with the conviction that, with modern implements, those distressing minor mental disorders might have been better and more effectively cared for. The future Sing Sing, in other words, will have to have a psychiatric clinic, and it seems to me that the present needs make it wise that this part of your undertaking should be entered upon at once."

This clinic, now functioning and representing the most advanced step yet taken in the state's dealings with delinquents and criminals, owes its existence in no small measure to the invaluable services of Dr. James.

Dr. James's activities in the interests of the mentally sick and his work for an enlightened penal policy in New York State led him logically to a similar interest in the feebleminded, and he soon showed the same remarkable grasp of this problem that he did of the others. In July, 1918, he was invited by the governor of New York State to assume the chairmanship of a Commission for Mental Defectives especially created by the legislature to study the problem of feeblemindedness. The identification of a large number of mentally deficient persons with crime, delinquency, and other social problems and the lack of adequate institutional facilities for their care and training forced public attention on the subject and brought about the organization of this body for the purpose of dealing constructively with it. Before that time New York State had no definite policy regarding the care and treatment of the feebleminded. Of the four institutions that then existed for them, each had its own governing statute and its own individual policy of care laid down by a local board of managers. There was no central authority with power to coördinate the work of these institutions, which operated under separate organizations with widely differing provisions. As a result of the work of this commission, the state has to-day a forward-looking, definite program of social control, involving the identification, registration, training, and community supervision of its mental defectives, more extensive institutional provision, and new and modernized laws governing the administration of this program. Dr. James saw clearly the ramifications of the whole problem of mental defect and pointed out the fundamental need of correlating the various governmental agencies that come in contact with it. His vision of a unified, coördinated state plan for dealing with the feebleminded pointed the way to the beginnings of a social organization for the control of the problem, involving better institutional facilities, colony care, community clinics, psycho-

logical testing, psychiatric diagnosis and study, special classes, social service, and so forth.

Dr. James had by this time become a "mental hygienist", and he gradually extended his interest in the subject on a national scale. Social-minded and civic-spirited as he was, he naturally took a keen interest in the public-welfare needs of his city and state, among which none claimed his attention and sympathy more than the proper care and treatment of the insane and the mentally defective. But it was the medical nature of the social problems that arise from the presence of mental abnormality in the community that appealed so strongly to the physician in him and impelled him to devote increasingly more time and energy to the field of mental hygiene. He identified himself more and more closely with the affairs of The National Committee for Mental Hygiene, consenting to serve successively as a director, as chairman of its finance committee, and as president. He assumed the responsibilities of the latter office during a difficult period of post-war adjustments and continued in it actively through the time of the organization's greatest growth (1919–1923). He seldom failed to attend meetings and regularly presided over the deliberations of the executive committee and the board of directors and at the annual meetings of the National Committee. He was a tower of strength and aided powerfully in the solution of one after another of the problems and difficulties that normally arise in the work of such an organization. His breadth of view, his statesmanlike grasp of mental-hygiene problems, his personal charm, his sanity and wit made association with him a privilege and a pleasure and contributed immensely to the advancement of the National Committee's aims and activities.

Perhaps his greatest contribution was as teacher of mental hygiene to the medical profession. Dr. James realized that one of the greatest obstacles to the advance of the mental-hygiene movement was the apathy of the average physician toward the subject of mental diseases. He threw the whole weight of his influence in the medical field into efforts to modify this attitude and secure the medical interest and sympathy so necessary for the success of the work. He lost no

opportunity to acquaint his colleagues in the profession, by his writings, by his talks at numerous medical meetings, and by personal interviews, with the great problem of mental and nervous diseases. He found his own mental-hygiene studies so revealing, and was so impressed with the possibilities for relieving a vast amount of human suffering in a field that was essentially a medical one, that he wanted his associates in general medicine to share his knowledge with him. He pointed out to them, for example, that almost every one of the patients in our mental hospitals had probably at some time in the early stages of his disease passed through the hands of a family practitioner, who apparently failed to recognize or even suspect the existence of a mental condition. He maintained that it was just as important for the medical student to learn psychiatry as it was to study chemistry, physics, biology, or the other sciences included under medicine. He was instrumental in securing the more adequate teaching of psychiatry in at least one medical school and, by his educational work among physicians in general, accomplished much toward the reunion of physical and mental medicine. Realizing that, as a result of the overspecialization from which general medicine has long suffered and of its preoccupation with physical diseases, the mind and its health had been pretty much ignored, he taught the importance of treating the patient as well as his disease, and by urging doctors to look to the mental as well as the physical health of their charges, he sought to restore to the community some of the benefits derived from the practice of the old-time family physician.

FORMULATING THE PROBLEM IN SOCIAL CASE-WORK WITH CHILDREN *

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IN one of those rare lulls that come to bedraggled pilgrims at a welfare conference, I found myself in conversation with two colleagues, both of whom have been active in community work for a number of years, one in a large Mid-Western city, and the other in an Eastern city. Suddenly one of them said in a hushed voice, "Can either of you tell me just what case-work is? I make recommendations that seem to me reasonable and practicable, and am told that they cannot be carried out because they are not good case-work. I send my own workers out and accomplish the social treatment that seems to me necessary to improve the health of the family. Why such procedures are wrong, I have never been able to discover. I have read such books as Richmond's *Social Diagnosis* and Bosanquet's *The Family*. Their methods of approach seem essentially the same as mine. Our goals are identical. I have talked with workers from different organizations, and so far as I can make out, there is no unanimity of opinion as to what the term 'case-work' really means."

I quote these remarks in detail because they express a sort of restless perplexity fermenting in the minds of many individuals to-day whose work brings them in touch with social problems and with the social organizations through which the treatment of these problems must be undertaken. For example, a recent number of the *Hospital Social Service Bulletin* sounds a warning note against too rigid attitudes on the part of hospital social service, quoting a New York City physician as saying that patients seemed to be coming to hospitals for social-service treatment instead of medical.

* Read at the Fifty-fourth Annual Meeting of the National Conference of Social Work, Des Moines, May 12, 1927.

In the world of social work there are many very dogmatic viewpoints. No two schools of social work agree on even a field-work program for training workers. Some believe that hospital social service should be included in the curriculum. Others do not. Some hug tightly the belief that nobody can do psychiatric social work without an apprenticeship in family case-work. Such credos, championed often with ascetic zeal, tend toward the formation of distinct units in the field of social work, each with its own regulations as to records, procedures of treatment, and so forth. The student entering such a unit for her field work often so focuses her attention upon the arrangement of details in a record that she is almost oblivious to the problem as a whole which she is studying for the purpose of treatment. How far is there real justification for these logic-tight compartments in social case-work? It is granted, of course, that certain workers are thrown more in contact with special phases of case-work than others. For example, the administering of relief, the contact with social customs and attitudes in communities of foreign born, contacts with legal machinery in the breaking up of homes and the commitment of children, are special aspects of social case-work that belong to the family case-work agency, the child-placing organization, and the probation worker rather than to the hospital social worker. In like manner, the hospital social worker and the psychiatric worker have certain special aspects of case-work associated with the contacts between medicine and social science.

The following of patients discharged from a psychiatric hospital, if properly done, is one of the most difficult branches of psychiatric social service. It requires a knowledge of the basic principles of behavior and a delicacy of human touch with which only an occasional worker is equipped intellectually and temperamentally. Yet I have heard such a worker described as not doing "case-work", but "merely follow-up work". Now, it seems to me that such special aspects of case-work technique are analogous to specialization in the field of medicine. Great care is taken that the medical student has a thorough grounding of four years' work in the principles of medicine before he is allowed to specialize in any department. This means that the medical internist, the orthopedist,

the pediatrician, the psychiatrist have one and the same method of investigating the patient's distress and are governed by the same principles of treatment, so that when the student has learned to construct his medical record for one department, he has learned to construct it for all. Special inquiries and techniques are easily acquired when the province of specialization is entered. In other words, the medical profession as a body speaks a common language, reciprocating its specialties easily and naturally, without any feeling of aloofness and mystery because dermatologist can get results in certain conditions that laryngologist cannot. Has social case-work a common language of methods of investigation and principles of treatment which is not being thoroughly utilized because technicalities of specialization are obscuring fundamental issues? I believe such a state of affairs does exist, and that it will continue to do so until social case-work is able completely to emancipate itself from the points of view of those early social reformers who were guided in their attitudes toward the treatment of dependency and other matters by economists.

The history of social science during the past century is checkered with conflict between economic theories and classifications arising from academic sources barren of first-hand experience with living human material and the insistence of an increasing group of field workers upon studying the individual and his social adjustment. The one would study the workhouse and the penitentiary as institutions; the other would study the individuals inhabiting these places and the stories of how they got there. This wave of individualism has spread into other academic fastnesses. Out of philosophy it has developed in progressive succession psychology, abnormal psychology, mental measurements, social psychology, and behaviorism. Entering medicine, it has transformed the rôle of behavior in the field of health from a scarcely recognized concept to a vital and well-established belief in medical science to-day.

It was logical, then, that when social case-work sought a constructive plan for its investigation of the individual adjustment difficulty, it should turn to those branches of science which deal with the study of behavior in the concrete set-

tings of human relationships. Now, in dealing with any problem of human distress, from the floundering college boy to the syphilitic, delinquent, neglected urchin, we are confronted with one and the same task, and that is reconstructing the setting of the particular difficulty in terms of the life story of the individual in all its various aspects. This should include factors of constitutional endowment, nutrition and growth, early environmental influences and habit training, history of the school period, sex adaptations, vocational struggles, and social adaptability (religion, amusements, recreation, neighborhood, and community affiliations). The facts of this story, as those of any other biography, must be arranged in an orderly and systematic form, with careful respect for chronology. Such topics should constitute the field of inquiry covered by every case-worker. They should be the common language of investigation of family case-worker, child-placing organization, probation worker, and hospital social service.

After this round-up of facts, the next step is to formulate the social problem involved in the story obtained. And right here is probably to be found an explanation of the fact that social case-work's weakest point seems to lie in its difficulty in formulating the problem of the individual or family constellation. Relief, child-placing, vocational guidance deal with needs common to large numbers of human beings, but the needs of no two members of any group present the same setting of facts. Theoretically, this is such a truism that it seems an insult to mention the fact to an audience of social case-workers. To be sure, we have traveled a long way from the eleemosynary point of view of the administration of relief toward the goal of helping the individual to help himself. We have found, through the trial-and-error method of experience, that certain principles of procedure are wise and wholesome as general plans of social treatment, such as the utilization of foster homes instead of orphanages. But sometimes, in our eagerness to follow the ideals of good case-work, we are guilty of sacrificing individual needs in a very unintelligent manner.

For example, Mrs. B. and the five children separated from her two years ago are brought for examination, with the

plan that the family be reunited. Mrs. B. is an epileptic with a mental age of 10 years who had two illegitimate children before her marriage to an alcoholic dependent. At the time of his disappearance and the breaking up of the family, two of the little girls were found to have gonorrhea and one syphilis acquired from a neighborhood contact. It has taken two years to clear up these venereal infections and put all five children in a satisfactory state of mental and physical health. Under luminal treatment and relieved of the strain of household management, the mother's convulsive seizures have been reduced to a minimum. Living in a respectable home, she is able to work steadily, earning $15 a week. It would seem obvious from even a common-sense analysis of the facts of this case that thrusting increasingly heavy responsibilities upon a mother so handicapped mentally and physically would result in exactly the same chaos as that from which this family was rescued two years ago. Yet a social supervisor still defends the plan on the ground that it is the aim of good case-work to "keep the family together".

In such failures to differentiate between individual needs and general principles of social treatment, it is the child who suffers most. Here, again, in theory we recognize childhood as the most constructive material with which we work in health and social science. Year by year we have gone about the care of dependent children more intelligently, as can be seen in the review of the work of child-placing agencies so admirably presented in a recent publication of the Children's Bureau.[1] There is a general agreement upon the importance of records, of the sizing up of health, of higher standards of foster homes and institutions. The weak spot in child placing is the tendency to talk about types of children (the delinquent, subnormal, degenerate) and to pay entirely too little attention to the gathering of facts about actual child stories, with the result that treatment is planned for behavior problems *in general,* instead of for individual children *in particular.*

[1] *Work of Child-Placing Agencies.* United States Department of Labor, Children's Bureau Publication No. 171. Washington: Government Printing Office, 1927.

Francis X. is brought for examination before placement with the following case summary:

> "The family was first known in 1920. Mr. X. appealed for a boarding home for Charles and Francis. At the time Mrs. X. was ill with tuberculosis and wanted the boys placed, in order that she might go to the country for the summer. In September Mrs. X. returned home and the family was reunited.
>
> "Nothing further was heard of them until June, 1926, when a report was received that the boys were mistreated by their stepmother. Mr. X. had married again, after the death of his first wife. No direct evidence of neglect could be found, and Mr. X. insisted that the children were well cared for. At the time the boys were attending school somewhat irregularly, and Francis was repeating the 4 B grade. He did not give any special trouble, though he was rather careless in his work and personal appearance.
>
> "On January 5, 1927, it was reported that Francis had been taken into the juvenile court by his stepmother for stealing a penknife. Mrs. X. complained that Francis was incorrigible and she wished to have him placed in the state correctional institution.
>
> "Investigation showed that Francis had stolen a wrist watch and a five-dollar bill before this. Mrs. R., the maternal grandmother, believes that the boys do not receive proper care and are often severely punished by Mrs. X. for little or no reason, and that good care and environment would improve Francis' conduct. Francis is in grade 5 B at School No. 65, and his report is good in scholarship, attendance, and conduct. Francis was a normal baby and has never had any serious illnesses. He gave no trouble as to his conduct until after his mother's death.
>
> "The case is referred for standardization of Francis. Should he be placed through legal adoption with his grandparents, Mr. and Mrs. R., who have a well-appointed suburban home, or in a correctional institution?"

In reading this summary, I find myself confronted with a boy thirteen years, four months, of age who is taken to the juvenile court by his stepmother for stealing a knife. The biographical story leading up to the misdemeanor is merely sketched in outline. From June, 1920, the date of the agency's first contact with the family, to June, 1926, the date of the second contact, is a period of six years. Many things have happened. The mother has died, the father has remarried. There are no dates for either event. In talking with the boy himself, I learn that after the death of his mother in 1921, he was placed with relatives in the country; that he returned to Baltimore when his father married again at the end of 1922; that he spends a great deal of time with his maternal grandparents. As for school, I learn that he went

to the third grade at the Pimlico School, spent over a year in the third grade in a county school, spent the fourth grade in School No. 65, and is now in grade 5 B in School No. 88. (The record states that he is in grade 5 B in School No. 65.) In five years this lad has had three different home environments and four different school environments. Experience has shown that frequent transplantations have as damaging an effect upon the roots of childhood as upon the roots of cabbages.

What is the character of the stepmother? In June, 1926, she is "accused of mistreating the patient and his brothers". How reliable is this accusation, and whence did it come? A similar accusation comes from the patient's maternal grandparents, who wish to adopt the patient. What are they like? We know nothing except that they have a "well-appointed suburban home". Upon these two statements I find myself quite unable to base an opinion as to whether they are fit guardians for the patient.

Coming to the stealing episodes of the watch, the five-dollar bill, and the penknife, one must keep in mind the principle that in evaluating any delinquency it is of the utmost importance to describe each episode in detail. From whom were these articles taken? Under what circumstances? What disposal was made of them subsequently? I learned from the patient that the watch and five-dollar bill were taken from the woman upstairs while playing with her children. One dollar was spent for candy and movies. The watch was to be carried a while and then returned. The knife was taken from the stepmother. Is the child telling me the truth? I do not know. These episodes make one curious as to where and with whom the boy spends his leisure time. Is he given spending money? Is he allowed to earn money?

Examination shows a sturdy, well-nourished-looking boy whose attitude is one of self-defense. His Binet-Simon test is satisfactory, coming up to about 13 years.

The problem is formulated on his record as: "Case is referred for standardization. Should he be placed through legal adoption with his grandparents, or in a correctional institution?" Evidently standardization is expected to answer that question. Standardization is not a diagnosis of

child or adult, but one of many aids to a diagnosis, just as is the blood Wassermann or the X-ray or urinalysis. It is impossible to formulate the social problem in this case without more facts along the lines that I have mentioned. Evidently in the mind of this worker Francis is a type known as the delinquent, and she formulates the social problem in terms of the treatment of delinquents in general—correctional institution or not? Francis is a delinquent in the sense that his stealing satisfies the technical definition of that term, but as Healy has been pointing out for the last twenty-five years, Francis is an individual delinquent and his antisocial behavior can be adequately interpreted only after a study of the entire setting in which it occurs. Theoretically, we accept the work of Healy, and the contributions of Goddard and Fernald, but in actual case-work practice we are apt to act upon the time-honored belief that the record of a child doesn't have to contain much—that his age, grade in school, conduct report, and list of illnesses are enough. I have heard the case record of a child characterized as "verbose" by a committee of case-workers because it contained some of the very facts omitted from the child's story I have just read.

In following the evolution in methods of treatment of the dependent child, one is impressed with the passing of the institution in favor of the foster home. As some one has expressed it, "Child placing is sold to the foster home." The theory of the foster home lends itself to a wealth of arguments, the chief point of which is that the child grows up as a part of a family group, which is the social unit to which he must adapt himself through life. Excellent social theory as this is, we know as yet too little about the behavior reactions of human beings to commit the allocation of children so hastily and completely to the foster home. First, there is the child as a variable human quantity to deal with. We can standardize his physical and intellectual status roughly, but we cannot standardize the emotional equipment of his personality, as it arises from a background of constitutional endowment and mutilating environmental influences, and predict its capacity to make new adaptations. Just here lies the difficulty in socializing the non-dependent child, whom we fre-

quently take from his home and place in boarding school and summer camp in an effort to study and meet individual needs.

The second issue in the placement of the dependent child is the environment into which we send him. In looking over the Children's Bureau publication previously mentioned, *The Work of Child-Placing Agencies,* one is impressed with the utter lack of unanimity of opinion as to the requirements of a foster home as expressed in the terms "high type" and "low type". Sanitation, economic status, and official moral standards constitute rough standardizing guides, but what about the inhabitants of these homes to whose personality idiosyncrasies the child has to adapt himself? Social science has done practically no research on the subject. The study of Sophie Van Senden Theis, *How Foster Children Turn Out,* made in 1924 for the New York State Charities Aid Association, is a good beginning. The studies now being carried on by Mrs. Edith Baylor of the Judge Baker Foundation in Boston should be valuable material. The data derived from "supervising" contacts as they are carried on to-day is pitifully inadequate when visits to foster homes average one in two months by agencies throughout the country.

Mildred, nine years, seven months, of age, is brought for examination. At two and one-half years she was permanently committed by the court to a child-placing agency, the father having been sent to the penitentiary for larceny, and the mother having been found to be chronically promiscuous. When the child was five years of age, the father was released from the penitentiary, and without gaining the consent of the agency, took Mildred with him to a boarding house in another state. As the boarding house was found to be "respectable", the child, although a permanent ward of the agency, was allowed to remain with the father, arrangements having been made with an agency in the other state to "supervise" the child in this boarding house. Eight months later, it was discovered by both agencies that the father had brought the child back to the old home and joined his wife. For four years Mildred was subjected to such irregular school attendance that truant officers complained, and the neighbors reported the child otherwise neglected. In November, 1926, Mildred received a mysterious burn on her arm. In order to

get medical attendance, it was necessary for the police to accompany the agency and remove the child from the home At nine years Mildred is an undernourished, unhealthy child with a mental age of not quite eight years. After a year of good hygiene and regular schooling, it will be interesting to see what the mental health of this child will show.

Lester K. is now ten years of age, and during the past five years he has been a continuous foster-home problem. So far, his intelligence quotient has remained 100, his physical health is satisfactory, and his teachers have no complaint, but he has been in eight different boarding homes during this five-year period and has been removed from each because of teasing younger children and animals and lying to get out of punishment. His latest offense is annoying truck drivers by pretending that he is deaf and obliging them to stop to avoid hitting him. Eight months spent among a group of children placed for observation in an institution showed a child whose energy and cravings to show off could be easily diverted into healthy channels of play and group competition. Evidently no foster home understands this child enough to meet his needs in this respect.

It is safe to assume that foster parents are subject to the same limitations as are natural parents in the matter of rigid attitudes with regard to the ethical treatment of petty lying and stealing and sex difficulties; that they share the common parental beliefs that the maladjustments of childhood can be divided quite simply into badness and nervousness for which punishment or medicine are panaceas.

A. B. was a girl of nine years when she was brought to us by her foster parents because of persistent lying, petty stealing of small change from home and school, aggressive indifference, Bolshevistic attitude in school, and auto-erotism. The patient was an illegitimate child who was given for adoption at two years by a child-placing agency to Mr. and Mrs. B., who were childless. She had a normal development, so far as neurotic and physical data were concerned. At four the foster parents began to notice the above complaints and took her to various doctors without improvement.

Examination of the child showed a physically satisfactory girl, with an I.Q. of 125. She admitted all the accusations

against her with an attitude of almost abstract indifference. The parents gave a perfectly smooth story with regard to training tactics and home influences, attributing all difficulties to bad inheritance. The child was placed for a period of study in the neutral environment of a boarding home, far enough away from Baltimore to cut off parental contacts, the parents agreeing not to visit her for a month. Two months here revealed the real facts of the case. The parents insisted on coming once a week, claiming that they could not bear the separation; they sided with the child against the boarding mother, who was attempting to carry out therapeutic suggestions given by us. For example, in an effort to interest the child in active play, to offset the auto-erotic activities, she was dressed in simple clothes, such as gingham dresses and sturdy footgear. A. B. rebelled in favor of her former dainty dresses and light pumps. She refused to walk half a mile to school with the other children, saying that she was accustomed to being carried in her father's car. Her conversation showed familiarity with beauty shops, movie stars, a popular love serial running in the local paper, and so forth. One day the foster mother arrived, and finding the child disheveled in a rough-and-tumble out-door game, rebuked her for so forgetting her parents to to behave in such an unladylike manner. I had a long talk with these foster parents of A. B., frankly telling them that they must choose between the health of this child and their own standards of foolish vanity which they wished to have exemplified in her. They insisted on picking on the unattractiveness of the boarding home, and finally took A. B. to Atlantic City for a month, to make up to her for what they construed as "ridiculous punishment". Our own contact with the case closed, and since then we have heard only indirectly of the child. A high-school principal telephoned me that she was on the point of expelling A. B. as a bad moral influence. (She had left school one afternoon with one of the boys and stayed out all night.) This teacher had asked the parents to bring the girl to us for examination, but they had refused, saying that they had already consulted our clinic and received no help whatsoever. A few months later the child-placing organization from whom they had adopted A. B. wrote me that these foster parents

were trying to take legal measures to return her to the organization as a "degenerate". Meanwhile these same parents had been given by the same child-placing organization another little girl, "to try for a few years, with the view of adopting her if she proved satisfactory". She was of good parentage and as pretty as a picture, so the organization told me. Last summer they returned this child, now eight years old, to the child-placing organization, saying that she had developed all the distressing behavior traits of the unlucky A. B. Examination of her revealed the same picture presented by her foster sister almost four years before.

It was hard to make this organization, or any other intelligent person or group of persons, realize that a home so satisfactory from the standpoint of hygiene, economic sufficiency, and church and club affiliations could be so absolutely demoralizing in its subtle emotional influences. It is indeed hard to put the latter into words, yet the two children reflect parental attitudes and conflicts that are unmistakable. The foster father is a hard-working man who has struggled to get on in life and keep up to his wife's expectations. Within the past few years their financial status has improved greatly. The foster mother is a woman who impresses one as making heroic attempts to put her best foot forward in every direction. One feels that clothes, household furnishings, and car are just a little bit better than she can really afford. It is she who undoubtedly sets the family living and social standards.

To furnish material over which she could better drape her vanities, she selected two pretty, attractive little girls, whom she tried to convert into French dolls. In her simplicity she forgot that these dolls were receptive personalities, richly endowed with the power of imitation. They copy her scornful attitude toward social inferiors, her overbearing manner toward servants and tradespeople, her distaste for and revolt against the irksomeness of routine, expressed in many a subterfuge. But when these habit responses are turned in her own direction, the foster mother becomes alarmed, and rationalizes her failures by blaming bad inheritance for the unhealthy behavior trends. For example, she would have A. B. punished for lying when she herself promised in the

child's presence not to visit her but once a month in the training home to which we sent her, and then went there regularly once a week.

Other important factors in formulating the problem in social case-work with children are the limitations imposed by the inelastic attitudes of the judiciary and economic straits which do not give the social agency a chance really to do a good piece of work. It is rare to find a court that sees beyond the immediate issue of an acute poverty or an episode of cruelty and neglect. The great factors of poor mental health lying behind such evidences of social distress are overlooked.

A few weeks ago a mother and her ten-year-old daughter were caught stealing from a department store. The woman said that she stole to get food because her husband had no work. The judge ordered a case-work agency to get the husband a job and to feed the family in the meantime. The husband is a chronic alcoholic; the wife a paregoric and morphia addict. They both have the psychopathic traits of drug habitués—profound untruthfulness and utter disregard of every responsibility. Three little children from four to ten years of age live under the influence of these two drug addicts. Could anything be more unintelligent than to order such a home kept together? Yet, to the judicial mind, vocational adjustment was the only issue for consideration.

In like manner agencies are given temporary commitment for the resuscitation of little children who in three to six months are put back again under the parental influences that formerly disorganized their health. Adults with deep-seated habits of alcoholism, gross irresponsibility, and mental dishonesty are expected to change the characteristics of a lifetime following a reprimand from the bench. Adolescent boys drifting into progressively serious misdemeanors are repeatedly given "one more chance" on the maternal plea that their support is needed, when inquiry into the actual facts fails to reveal a single evidence of wholesome habit formation in lads who have stolen from their mothers since early childhood.

The importance of the stabilizing influence of habit training in the individual emerging from childhood into adolescence cannot be sufficiently emphasized. Stella's father died

when she was seven years old, and her mother a year later. Stella went to live with an aunt, who struggled to break her of stubbornness and tantrums until June, 1924, when she was turned over to a child-placing agency. After trial in three boarding homes, where she stole a bracelet, wet the bed, and had tantrums of screaming, Stella was brought for examination. At eleven years of age she presented a picture of sullen discontent and touchiness, with other evidence of such poor social adjustment that we advised her placement in a small school for girls where there is an unusually intelligent training. From October, 1924, to January, 1925, she remained at the school and made an excellent adaptation. Because of the agency's lack of funds to spend on children of this age, Stella was turned over to the City Charities, who took her from this school and placed her in a free home (March, 1925). She again became the same problem as before. In May, 1925, she was transferred to the home of a maternal cousin, and in January, 1926, a paternal uncle took her. Here she stole money, stayed out all night, and made sexual advances to a male cousin. In October, 1926, she was returned to the agency who had taken her at eleven years. At present writing, she has been arrested and committed to a correctional institution.

Failure to formulate the social problem in this child's case is all too obvious. Had Stella remained in the school where she was placed in October, 1924, there is no doubt but that she would have been a stable adolescent to-day. It would have been cheaper, humanly and economically, for the agency to have kept Stella on at the school, but it was asking too much to expect them to make an exception to their usual budget policy in this particular case.

In presenting this critical review of social case-work's approach to childhood, I am humbly aware of the fact that I have never done field work in social science—that I have never felt the pressure of neighborhood prejudice, or been obliged to listen patiently to the dictation of some unintelligent critic speaking from the Olympus of one of the professions. Were I continually subjected to such psychic traumata, I am certain that vision of the large social problem would at times become very dim. My faith in social case-work was never

greater than it is to-day. Without it, so-called public welfare would be empty and meaningless. It has so much to give, not only to the educating of its clients, but to the educating of the medical, legal, and teaching professions, whose gross ignorance in practical matters of social science too often constitutes a handicap far greater than that of the maladjusted helplessness to which it is called upon to minister. Family case-work, child-placing organization, probation worker, hospital social service, psychiatric worker have identical goals and work with common human material. Their methods of individual case study and the principles underlying the formulation of their problems are the same. United on these fundamental issues, they stand as did the Thirteen Colonies, a tower of strength to those who need help in finding themselves, and a formidable unit of defense in behalf of the constructive progress to which their work contributes in the cause of civilization. With such ideals for realization, social case-work cannot afford to split hairs over trivialities, or to bicker over details of specialization in treatment, or hastily to declare itself "sold" to some one point of view without establishing a solid body of facts upon which its theories are based. The goal of achievement in social science cannot be measured by academic credits or standardized curricula or the zealous espousal of any set attitude—social, educational, or psychiatric. "The most telling measure of wisdom and balance of a program", said Adolf Meyer, in his address before the National Conference of Social Work in 1925, "is that of simplicity, and the cultivation of sane common sense. . . . . We should be able to prove ourselves well-balanced and especially thoughtful also in the great task of dealing with the accumulated wisdom concerning habits of life and habits of thought and habits of feeling—æsthetic, moral, and religious; capable, when called upon, of a helpful vision of spirituality and morality and conscience."

PSYCHIATRIC SOCIAL WORK IN A GENERAL MEDICAL DISPENSARY *

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IN a discussion of psychiatric social work in a general medical dispensary, the relation of psychiatry to general medicine must be considered as well as that of psychiatric social work to general medical social service. Psychiatric clinics in general medical dispensaries have increased rapidly in the last fifteen years. This has been in accordance with the growth of public interest in mental health and the increase in the number of hospitals and dispensaries throughout the country.

As early as 1885 a clinic was started in the out-patient department of the Pennsylvania General Hospital "for advice and treatment of mental diseases in their earlier or incipient stages, working among the poor and indigent where such diseases had not so far progressed as to require restraint within the walls of the hospital".[1] Later, in 1898, a "mental clinic" was established at the Boston Dispensary. Before that a neurological clinic had existed which included both mental and nervous diseases. Michael M. Davis, writing with Miss Mabel R. Wilson, in 1913 pointed out that "mental clinics" had usually been conducted in hospitals or institutions that specialized in mental disorders, and had rarely been managed as adjuncts of general hospitals or dispensaries. They felt that there was a distinct place for such clinics there, however. They indicated also that organized social service was not only an invaluable accompaniment of such clinics, but essential to their efficiency.

Following this first establishment of adult "mental clinics" has come the organization of numerous "neuropsychiatric", "psychiatric", and "mental-hygiene" clinics for adults in

* Read at the Fifty-fourth Annual Meeting of the National Conference of Social Work, Des Moines, Iowa, May 13, 1927.

[1] "The Psychiatric Clinic in the General Hospital", by Irving J. Sands, M.D. *Journal of the American Medical Association*, Vol. 85, pp. 723-729, September 5, 1925.

dispensaries. Children's clinics have also been started, planned in accordance with the newer developments in child psychiatry, as exemplified by the child-guidance clinics of The National Committee for Mental Hygiene. These, in turn, are possibly giving an added impetus to the organization of adult clinics along the same lines—that is, with the triple personnel—psychiatrist, psychologist, and psychiatric social worker—and with a greater emphasis than before on the social factors. Some institutions have clinics for children and clinics for adults, where the staff of psychiatrists includes specialists in both fields. As yet there has been no corresponding recognized specialization so far as the psychiatric social worker is concerned. However, authorities in the education and training of these workers may be considering this as a future possibility.

The report of a committee that surveyed hospital social service in 1921 described the psychiatric social worker as one who "may be said to bear the same general relationship to the medical social worker that the general practitioner of medicine bears to the specialized psychiatrist. The number of people whose physical difficulties are based upon nervous and mental conditions makes it necessary for certain physicians to specialize in psychiatry. Similarly, the large number of persons whose difficulties, both medical and social, are of this kind . . . makes an especially trained group necessary."[1]

An erroneous impression is sometimes held that psychiatric social work in a general medical dispensary means, as a rule, work entirely with adult patients. For the most part, as it does deal with adults, it may be with patients who have been diagnosed as having mild personality difficulties. Frank cases of mental disease are, of course, also seen in the dispensary. This group, however, is not one from which the majority of cases for intensive social service would be taken. In these cases the psychiatric social worker may well serve in the more limited capacity of securing the outside history as an aid to diagnosis and of carrying out immediate recommendations, such as admission to a psychopathic hospital.

[1] "American Hospital Association Report of the Committee on the Survey of Hospital Social Service." *Hospital Social Service*, Vol. 3, pp. 1–21, January, 1921.

In the case of children, the psychiatric clinic in a general medical dispensary may frequently deal with the youngest group and with behavior problems or difficulties in their early stages. This is true because physicians in other clinics of the dispensary may themselves, or with the aid of their general medical social workers, detect early symptoms and recognize cases for the psychiatrist, when these might not have reached an independently organized psychiatric clinic until the deviations had progressed to the extent of the patient's becoming a social menace or at least a recognizable social problem.

The following case is an example of psychiatric symptoms detected through complaints about a physical condition.

> Joe is a boy of fourteen years who, after the death of a school-teacher from heart disease, believed his own heart to be seriously affected. He had been in bed for several weeks on this account. There being no physical findings, the patient was referred to the mental-hygiene clinic. This offered an opportunity for uncovering other and possibly more significant fears. In this case the boy worried over masturbation, and centering about this there was found to be serious conflict. A diagnosis of "anxiety neurosis" was made. After two visits to the psychiatrist, the patient returned to school. Through the social service, other adjustments have been made in relation to attitudes of members of the family, recreational contacts, a scholarship to permit the boy to continue school, neighborhood conditions, and the economic situation. The complaints in regard to his heart led to the unraveling of a number of psychiatric and social difficulties. At the end of one and a half years this boy is making a very satisfactory adjustment. By getting the case when the clinic did, there was a better chance of success in treatment than if the difficulties had progressed to the point where the case might have been sent to a community psychiatric clinic by the school authorities, for example.

The general medical hospital and dispensary is a very logical and satisfactory place, among others in the community, for the location of a psychiatric unit. Occasionally dispensary clinics extend into the hospital. Other general medical dispensaries have clinics with no formal connection with the hospital and with no psychiatric service yet available to the hospital staff. Certain other general medical institutions have developed to the extent of having special psychiatric hospitals, as at the Colorado General Hospital and at Johns Hopkins Hospital. The unit most frequently seen to-day is the one located in the general medical dispensary, which may or may not extend in some way to the hospital.

It is known that there are psychiatrists on the staffs of at least fifty-five general medical institutions in the United States in the group of those that have general medical social service. At least nineteen of these centers are organized with a psychiatric social worker, a psychologist, and a psychiatrist.[1]

We may think of the unit in the general medical dispensary as one that requires the same personnel, is organized along the same lines, has the same functions, and performs essentially the same services as psychiatric units elsewhere. A psychiatrist on the staff of a general medical institution is the starting point for the establishment of a complete unit and makes possible the institution of psychiatric social work.

There are certain special features to be noted in connection with the general medical dispensary as a place for the development of psychiatric social work. Such a center may involve educational work within the larger institution and a gradual growth to what is felt to be an adequate organization. It is less apt to offer the immediate spectacular opportunities found elsewhere. Freedom to develop the social work with the psychiatrists is of primary importance, whatever the particular system of organization in relation to the general medical social service may be. Also, departments very often start with one psychiatric social worker, who must plan her time very carefully if she is to pave the way for a well-rounded department. For example, she obviously should not continue long to do the clinic management. This is a big and important piece of work in itself. Next, she must make a decision as to the amount of time she will spend on the various phases of the work—intensive social case-work, so-called "short-service" work, advisory work with the social workers of outside agencies and with the general medical workers on cases that have been referred for examination in the clinic, history getting as an aid to diagnosis where social treatment is not undertaken, medical follow-up to secure the return of patients for completion of examination or for treatment, general educational talks, and informational service. All of these would seem rightfully to be the responsi-

[1] Report of a Committee to Study Social Work in Neuropsychiatric Clinics and Departments in General Medical Hospitals and Dispensaries, American Association of Psychiatric Social Workers, May, 1927. Unpublished.

bility of the psychiatric social worker here as in units organized elsewhere. Local conditions make for varying emphases. It would probably be agreed, however, that all workers should include, from the beginning, a certain limited number of cases taken for complete case-work, to serve as a logical foundation for the other services.

The mechanical feature of having the neurological and psychiatric clinics separated is of significance. There are surely neurological cases that do not need the care of a psychiatric social worker any more than the strictly general medical cases. If the worker is responsible for both the neurological and the psychiatric cases, the number of short-service cases, for example, that need immediate attention among the larger number of neurological cases might well result in crowding out the intensive social investigation and treatment needed in the psychiatric cases. Whether or not, so far as medical organization is concerned, the two clinics should be under the same director is another question and is not primarily a concern of the psychiatric social worker.

If she gets a wrong emphasis on her work in the beginning, the psychiatric social worker may be unable to bring back to the psychiatrists the information that makes for an increased feeling of need for what she has to contribute to examinations and treatment. To make the adult psychiatric clinics just as much social psychiatric clinics as are the children's clinics should be the goal of workers starting in general medical dispensaries. At the present time it may be said that the strictly neurological cases, among the adults at least, should be left with the general medical service.

Psychiatric clinics in general medical dispensaries are probably less well organized on the whole than are many of the special clinics elsewhere. Although the unit made up of psychiatrist, psychologist, and psychiatric social worker, aided by the clinic manager and adequate stenographic help, is found in general medical dispensaries, frequently such dispensaries are not yet so completely staffed. This means that there may be relatively fewer good opportunities for positions in well-established clinics.

There may be less call for general educational talks to groups from psychiatric social workers in general medical

dispensaries. This, of course, depends upon a number of factors, but it is true that psychiatric social workers are less sought here as the possessors of a new panacea. Their advice is taken as a part of a whole medical study and comes from a larger institution with which outsiders are already familiar. This has an advantage in making for sound growth. It may, however, also mean a postponement of the development of the advisory service to outside agencies—always a most important division of the work of any clinic.

Another point that should be mentioned is the fact that the majority of psychiatrists are part time and unpaid in dispensary work. They are not as readily available as those who are employed on full time by specialized psychiatric agencies. Therefore, the psychiatric social worker, in coöperation with the clinic secretary, has to plan carefully in order to use the psychiatrist's time to the best advantage. An appointment system allows for a limited intake, which is essential. These part-time psychiatrists often have interesting connections with other clinics in the community and volunteer at the dispensary because of the opportunity for special experience it offers. Some staffs include both paid and unpaid psychiatrists.

Probably the possibilities for research are at the present time more limited in psychiatric-social-work departments in general medical dispensaries than in specialized clinics. This, of course, depends largely upon the stage of development of the department. When psychiatry is a vital part of the general medical organization, then there should be no fewer opportunities for research in this branch of medicine than in any other. The same should apply to research more particularly in psychiatric social work.

In her case-work processes the psychiatric social worker in the general medical dispensary has certain advantages.

The patients who come to the mental-hygiene clinics at Michael Reese Dispensary, for example, have often been to other clinics in the dispensary and frequently to a number of them. They may also have had extensive laboratory tests. The results of these examinations are available to the psychiatrist and are of value as history on individual social-service cases. Later additional examinations in the general

medical clinics are of help to the psychiatric social worker in formulating plans for treatment.

Other interesting features grow out of the fact that facilities for the psychiatric examination and treatment of both children and adults are available in the same institution. The examination of an adult may bring to light a problem in the child, while the investigation of a child's difficulty may indicate the need for an examination of the parent. Such further examinations can be brought about in a natural way and can be conveniently obtained. There is an advantage in the joint consideration of a family by the psychiatrist interested in the child and the psychiatrist from the adult clinic who is treating the parent. Association both with psychiatrists who specialize in work with adults and with those who specialize in the children's field is of great educational value to the psychiatric social worker.

Individuals are generally more willing, at the present time, to come to a general medical dispensary for help with problems that have to do with mental health than to an institution where only such problems are treated. The name of the clinic is used quite freely at Michael Reese Dispensary, however. The routine stationery of the department has "Mental Hygiene" in its heading, and the effect of this has been rather carefully watched, but no untoward reactions to it have been noted. Sometimes on postcards abbreviations will be employed, but otherwise the name of the clinic is used as freely as is the name of any other clinic.

Lastly, it may be mentioned that in addition to heading up the psychiatric social work in a general medical dispensary, the psychiatric social worker is apt to be called upon to help in the administrative duties of the clinic, both within the clinic and in its relation to the dispensary as a whole and to outside agencies. This is due to the fact that the psychiatric social worker is on full time, whereas the psychiatrist and psychologist are usually on part time.

To get some idea of the possible interrelationships between general medical clinics and mental-hygiene clinics, the opportunities for the interchange of written reports between general medical doctors and psychiatrists have been studied in 67 cases. These were the cases referred from general medical

clinics and the hospital out of a total of 139 new cases referred to the adult mental-hygiene clinic at Michael Reese Dispensary during a typical year. This clinic receives its cases almost entirely from the doctors in the other clinics and from family case-working agencies. Almost half of the new cases during the year in question were referred by general medical physicians. The children's clinic would have shown an even larger proportion of cases referred from this source. This is due to the fact that there is less pressure here from social agencies, since there is other provision in the community for the psychiatric examination of children. On the other hand, there is less adequate provision for the examination and treatment of adults, and hence necessarily more use of this clinic by social agencies. Also, physicians and general medical social workers, until they are familiar with psychiatry, are more apt to detect and to be impressed by various behavior problems in children, as they come through the clinics, than they are by the more subtle symptoms of possible mental or nervous disease in adults. Then, too, psychiatric work with children is undoubtedly more popular than is the work with adults, which is still bound up with ideas of incarceration rather than treatment, of the need of state provision for these people, and often with an unwarranted feeling of hopelessness.

In this study the points noted were the clinics that referred patients, their reasons for sending them, the diagnoses made in the mental-hygiene clinic, the frequency of the return of patients to the clinic from which they came, the number of other clinics to which the mental-hygiene clinics sent patients, and, lastly, the number of cases in this group that were being carried by general medical social workers. This last, of course, would have a bearing on the opportunities for interrelationship between this social service and the psychiatric social service.

Nine other clinics in the dispensary had referred the 67 adult patients, the largest group, or 38 of the 67, coming from the general medical clinic. Ten came from the neurological clinic, six from the tuberculosis clinic, six from Michael Reese Hospital, three from the gynecological clinic, and one each from four other clinics.

It was interesting to go over the reasons given by the various medical clinics for referring patients to the mental-hygiene clinic. They included tentative psychiatric diagnoses, such as "neurasthenia" and "psychoneurosis". Frequently the physical findings were negative, but complaints continued, and so the patients were referred. Certain of the records gave a helpful statement of symptoms that had been noted either in the history or from observation of the patient in the clinic. Among these were such statements as, "Wakes at night. Excited. Feels his mind is changed. Nervous breakdown ten years ago. One brother weak in head. Mother nervous. Transfer to Mental Hygiene"; or, "No sufficient physical findings. Fainting spells. Claims he can't work. No active lung findings"; or, "Nervousness over domestic friction"; or, "Fixed facial expression. Hears voices. Sees things. Feels weak and dizzy. Refer to Mental Hygiene." Occasionally the physician mentioned that he had referred the patient for "study and advice". Sometimes the reason for requesting a psychiatric examination was not stated. In certain of these latter cases the reports sent by the social agency to the general medical clinic indicated the reason for referring, as in one report, for example, where "dissatisfaction with work" was mentioned, and a request was made for a psychiatric examination to aid in social plans for the patient. In one particular case, the doctor in the surgical clinic, who had treated a patient in the hospital and later in the dispensary, referred the man because of his attitude on the wards in the hospital. The patient had been rude to the nurses and had done troublesome things, such as opening bandages. In this instance the surgeon wanted advice as to how to cope with the attitude shown. It so happened that the patient was found to be a case of paranoid dementia praecox with delusions rather definitely associated with the alimentary tract upon which the surgical operations had been performed. The man, incidently, was found to be homicidal and it was necessary to send him to the psychopathic hospital.

A review of the various diagnoses showed that the entire group would be considered cases that needed examination in the mental-hygiene clinic. Thirty-six reported for examination only, while 31 continued to come for treatment afterward.

This means continued opportunity for an exchange of reports.

Only 9 out of the 67 were expected back in the referring clinic at the time the patient went to the mental-hygiene clinic. It was found, however, that at the time the study was made, 21 had actually returned, while 46 had not done so. Occasionally, of course, doctors may have asked to see records after examinations, and in other instances the social worker particularly interested may have brought the records to the attention of the doctor in the absence of a report from the patient.

Further light on the interrelationships of the clinics may be gained from a study of the other clinics to which the mental-hygiene clinic referred patients. Thirty-nine were not referred to any other clinic, while 28 were referred, one of them to as many as six other clinics. The largest number were referred to the ear, nose, and throat, the eye, the medical, and the physiotherapy clinics. Nine other clinics were used, however, as were also the laboratory and the X-ray department.

In addition to these opportunities for the interchange of reports and whatever other clinic contact there may have been between the psychiatric clinic and the general medical clinics, 6 of the 67 cases were being carried as intensive social-service cases by the general medical social service. Hence, there were 6 examinations made in this group of new adult patients that directly affected the general medical social case-work and that offered opportunities to the psychiatric social worker for doing advisory work as consulted.

Of the large number of cases that attend the general medical clinics and the mental-hygiene clinics, certain ones will become cases for the general medical social workers and others for the psychiatric workers. This will depend upon what is considered the primary difficulty. The psychiatric social worker may be carrying a case in which there is a general medical problem. Take the case of a child presenting severe behavior problems who has indulged in sex practices with an adult with a resulting infection. The general medical social worker in the vaginitis clinic helps the psychiatric social worker in her plans with the family by

informing her as to the necessary hygienic measures and the situation in regard to the possible infection of others, keeping her in touch with the most recent methods in the clinic for the treatment of such cases.

In turn, the following case will show the general medical social worker using the children's mental-hygiene clinic in relation to an intensive social-service case referred by the pediatrics clinic for examination.

> The case was that of a boy of eleven years, small in stature, whose diagnosis in the pediatrics clinic was "malnutrition". Because his mother complained of a change in the boy in the last year and a half, which manifested itself in various ways, he was referred to the children's mental-hygiene clinic. The mother had noticed enuresis, disturbed sleep, restlessness, fussiness in regard to food, a tendency to be a poor mixer, and irritability. She said that she was unable to train the boy. The general medical social worker, carrying the case as one for intensive social service, sent the initial psychiatric social history according to the outline and received the written report from the clinic upon completion of the examination. Informal supplementary conversations have been held in the clinic and subsequent written reports will be exchanged. Some of the specific psychiatric recommendations given to the general medical worker for use in her social treatment were the following: "1. Do away with the mother's over-solicitous attitude toward the boy's health and have the teacher discontinue special favors. These tend to keep alive a feeling of inferiority which the boy possesses. 2. Place the boy in a recreational group where intellectual superiority will be minimized. The child is extremely egocentric and has overcompensated his feeling of physical inferiority by a feeling of intellectual superiority of which he is aware. (I. Q. 138) There is an over-determination to dominate. 3. Let the worker have little direct contact with the patient, since he is getting considerable attention as it is. 4. Supervise his reading. He is fond of books on heroic achievements and he needs a more balanced program, of classical literature commensurate with his mental age. He is reading books that foster his ideas of being superior and conquering. 5. Have patient report regularly for psychotherapy for the purpose of removing the feeling of inferiority." The general medical social worker has incorporated these recommendations in her plans for the family. There has been a marked improvement in the child in the last four months. He has got over his desire to be fictitiously superior, realizing that it is more important to acquire a social feeling and that he gains more by being one of the crowd and doing good work than by being ostracized from the crowd because of his superiority. He has acquired friends in a recreational center and in the place where he was most unpopular—the manual-training class.

This boy ran the chance of becoming a social outcast. He was misbehaving in the home, if not yet in the community. It

may be assumed that without treatment he would have developed a more defiant attitude and have committed actual misdemeanors to put himself in the limelight.

The opportunities for interrelationships between psychiatric social work and general medical social service are evident. Adequate records showing how the psychiatric social worker has done better case-work because of her approach should be available from the beginning. Opportunities should be welcomed of serving as consultant to the general medical social workers in their cases where there may be psychiatric as well as medical problems and where the patients or members of the family may have been examined in one of the mental-hygiene clinics. Further, staff meetings may readily be opened to general medical social workers and direct access to the psychiatrist arranged.

As brought out before, the procedure of the psychiatric social worker in a given case is the same in a general medical dispensary as in other clinics. A particular case has been chosen, however, that shows important correlations of the findings in the general medical clinics with those in the mental-hygiene clinic. It is a case in which there were severe abdominal pains and apparent hearing difficulty closely associated with psychiatric phenomena.

Bessie, a Jewish girl of fifteen years, was brought to the children's mental-hygiene clinic at Michael Reese Dispensary by her mother after a third episode of wandering away from home. She had been picked up in Waukegan by the police. Her mother was afraid to let Bessie return to school or to leave the house alone for any other purpose.

Bessie has attractive and pleasing qualities. She is a well-developed and healthy-looking girl. As she waits in the clinic, people comment on her attractive boyish bob.

The history secured by the psychiatric social worker showed Bessie to have always been different from the other children in the family. She was a "difficult child". She had always laughed and cried readily. She did not do the things that other girls her age did. She had no friends. Recently, she had remained most of the time by herself. There was undue reading of "anything she could lay her hands on". She helped very little with the housework. Several instances of stealing from relatives were given, following which there had been anonymous gifts, once a large package of greeting cards. She was failing in the first year of high school. More recently she had become a problem there by destroying books and remaining away from the classroom for long intervals. No history was elicited of nervous or mental diseases in the family.

Bessie was born in Russia, coming to this country at four years of age, since when she has been in Chicago. She lives in a comfortable six-room flat on the northwest side. The rooms are neatly and rather massively furnished. Her father and mother, her sister Rose, aged ten, and her brother Louis, aged thirteen, are in the home. The patient sleeps with her sister. There are three other siblings married and living in Chicago. The patient's father has a news stand and works nights, averaging $30 a week. The family has always been self-supporting. The patient is in the first year of a two-year vocational course in high school, but has not been attending regularly. She has never shown any particular interest in religion.

The members of the immediate family group may be described as follows:

The mother is an active, intelligent woman of forty-four years, with limited education. She is hard-working, efficient, and ambitious for the family, including Bessie. She is learning that the patient is not like her other children and that she must not expect as much from her. She has long been the dominant influence in the home and maintains the respect of the family. She suffers from severe headaches, as did her mother.

The father is a rather ineffectual-appearing man, easily influenced by the mother. He is uneducated, rather dull, and at times shows a severe temper. He has struck the patient, but is afraid now to cross her or scold her as he has done in the past, for fear she will run away. As a result of his working at night, he and the patient see very little of each other.

The younger sister in the home is quiet and well behaved. Her school work is excellent. The mother favors her and spares her from work in the home, since this would interfere with her privileges—her music lessons and Hebrew school.

The brother is in high school. He is self-sufficient, rather boisterous, and inclined to keep himself well occupied.

The significant findings of the psychiatrist were as follows:

"Psychotic trends and emotional poverty toward social environment. Antagonism toward members of the family, especially the mother, dating back to trauma at age of four. Delusions of sex approach. Prevarication and petty stealing as a defiance to exert superiority. Unpremeditated fugues at ten, twelve, and fifteen years. Smile without any external stimuli, with thought content contraindicating it. Immaturity of reaction out of proportion to her intelligence quotient of 100.1. Markedly introverted. (Physical examination refused and not done because of manifest psychotic tendencies.)"

Points of attack by the psychiatric social worker are obvious.

During two years social and psychiatric investigation has continued and changes in the home as well as in patient's other community relations have been attempted, along with the treatment in the clinic. Here Bessie was under analytic treatment by the psychiatrist for three months. This was terminated when increased negativism was noted, it being felt dangerous to go on for fear of precipitating a psychosis. The work was then carried by the psychiatric social worker, she only having direct contact with the patient, but getting frequent advice from

the psychiatrist in her continued efforts to bring about a more satisfactory social adjustment. Certain special information has been needed by the psychiatrist from time to time. This has had a very definite effect on diagnosis and treatment and also has been of social significance. For example: Were statements of sex abuse by a brother-in-law based on fact, or were these phantasies of the patient's, as thought highly possible by the psychiatrist? How did Bessie react after the first time she was observed stealing? And obviously, as in all such cases, there were a host of other data needed.

The plans of the social service have included work directly with the patient, and work with those in the patient's environment, both in direct relation to the patient's difficulties, and also regarding various matters not associated with the patient that presented themselves. Practically the plans have resulted as follows:

An effort was made to fill Bessie's time so that she should be consistently occupied during the day. A schedule for the housework was made out with the mother. Bessie was readmitted to school, the interest of the dean and the room teacher having been secured. A recreational contact was made for her, the club director knowing certain of her particular characteristics. He was anxious to try to fit her into one of his clubs. The girls liked Bessie, and she took a rather active part in club activities until after several months stealing of money was suspected. Both the recreational director and the girls in the club, who gradually learned that the patient was a little different from ordinary girls, felt challenged to help her. The club girls even elected her vice-president, believing that this responsibility would be good for her. Bessie made friends here. She was glad to take her mother and the worker to entertainments.

Her school work was good for five months and then she had difficulty in shorthand. She preferred to go to work, and when she had had sufficient training for this in the second year, she was allowed to stop school and was placed in clerical work.

Neither of two positions found was entirely suitable, but while efforts were being made for more satisfactory placement, stealing was suspected by an employer and soon afterward an instance was evidenced at the employment bureau. It was then difficult to find an interested employer. The experiment was tried of admitting Bessie to the Industrial Work Shops of the Federated Jewish Charities. This is a commercial shop for handicapped persons, and Bessie is in the machine sewing room. Her supervisor knows her propensities and Bessie feels some protection because of this. The work is systematic and intelligently supervised. Bessie has been here two weeks and is giving satisfaction in every way. There is less likelihood of her stealing under these circumstances. The hope of placing her again in the community is being kept in mind and also the possibility of using her clerical training again.

In psychiatric social work, in particular, it is important to analyze carefully the relationship that the social worker may have to the individual patient. Often the psychiatric aspects of the case-work may be shown up conspicuously

here. Frequently, of course, as in some children's cases, the work may be entirely with others than the patient, and often it is advisedly so. However, this relationship, positive or negative, is always interesting to define.

The girl whose case has just been cited was considered by the psychiatric social worker to be a mentally sick person, a border-line case, whom we hoped to bring safely through the adolescent period. With Bessie the psychiatric social worker realized first of all the importance of securing the confidence of the girl and being constantly and easily available to her, so that when she was discharged from her place of employment, and when she had "left home", as she put it, after her one severe quarrel with her father, it was easy for her to come to the worker, who, in turn, paved the way for the girl's return to her family. She was made to realize that the worker was interested in everything she did because we wanted her to get along well in all respects. Obtaining a close contact was particularly important in this case, and special recommendations for it were received from the psychiatrist from time to time. For example, he made the specific suggestion that any interest on the part of the patient in the matter of pleasing the worker should be encouraged. It proved later that when mutism had almost been reached in the interviews with the psychiatrist, the psychiatric social worker continued with the patient with no difficulty.

Behind all there was a drive to keep the patient stimulated and interested in something in the world around her—to work against her unhealthy tendency to introversion. School, friends, occupation in the home, care of clothes, and, later, outside employment were assumed as natural activities for Bessie, and a stimulation of interest in these was sought. An effort was made to appeal to her pride, as in regard to her appearance. The worker asked constantly about things in which it had been noted the patient was beginning to show an interest, as in her new acquaintances or in the fixing up of old dresses with ribbons or the retrimming of a hat. The worker and patient recognized that the latter had real difficulties which together they were trying to overcome. Bessie knew also that the worker was endeavoring to help her mother to understand her. Stealing and running away, two of the

most significant social problems, were not fully discussed by the social worker until the underlying causes were determined by the psychiatrist. Learning, however, as the case progressed, that the stealing was a defiance and an anal-erotic gesture and that the patient was conscious of it, we realized that there might be value in our talking of it. Further, at the request of the psychiatrist, we pointed out to the patient what he believed to be the mechanism behind her stealing—that is, that she was thereby defying authority and upsetting her mother, the worker, and others.

Contact by the social worker with teachers and others has been indicated. The work with the relatives directly in connection with the patient's difficulties was primarily concerned with the mother, she being the one who has had the most to do with Bessie. After considerable difficulty, she was persuaded to plan the patient's work ahead and possibly to remind her once of what was to be done, but to refrain from nagging. It proved that Bessie was willing to do work assigned to her in this way. Through the mother the coöperation of the father was secured. She prevented their coming together when this would have meant friction. The mother's coöperation in reporting changes to us was secured. Encouraging features in Bessie's adjustment were emphasized with the mother. The worker agreed to assume a certain responsibility for the patient, thus relieving the mother. Rose, the younger sister, was encouraged to take some part in the housework.

Social problems not in direct relation to the patient, in the family and community as a whole, have been watched for. Proper medical care for the mother and father, a tonsil and adenoid operation for the sister, advice for the mother and father in relation to the investment of money, and camp placement for the brother and sister, have been secured. An effort to protect the community from the patient's stealing has also been considered.

Physical factors in relation to the patient have been noted from the beginning in this case as in others. Consideration of apparent physical needs, such as dental attention for a missing front tooth, improvement in care of person, the need for speaking out more distinctly, were immediately a part of

the psychiatric-social-work plan of treatment. A suitable opportunity for a routine physical examination was to be hoped for.

In this case there were two particularly interesting opportunities to use the general medical clinics in direct relation to the psychiatric symptoms.

The family had told of Bessie's cramps, when she would lie curled up on the bed for two hours at a time. Bessie would smile as she told of them to the worker. It was necessary to find out if there was any serious physical difficulty. At a time of unemployment it was possible to get the physical examination that was wanted. Bessie's being out of employment was displeasing to her mother; having a physical examination would meet with the mother's approval. It would also better enable the social worker to place the girl in another job, which was what Bessie wanted. Bessie agreed to the examination.

At the suggestion of the general medical social service, the psychiatric social worker talked directly to the doctor in the general medical clinic who was to examine the patient and gave him the psychiatrist's summary. He was interested, took considerable time, and had no difficulty in completing an examination. A laboratory test and examination in the cardiac clinic were recommended. Both were done and proved negative, and it was felt that the patient's general physical condition could be considered negative.

The psychiatrist then expressed the belief that the cramps were probably conversion symptoms—escape gestures like her fugues and her lapses of memory during reading. She frequently looked at books for long periods without knowing what was in them. This being the case, we had to keep in mind the possibility of the patient's consciously or otherwise using these as an escape from unpleasant situations.

The patient showed difficulty in hearing at two places of employment. At her first job her employer reported that she could not hear well over the telephone, and the next employer said that her dictation was inaccurate and accredited it to poor hearing. The patient had a tendency to dream off when being spoken to at times, and we did not know how much of her difficulty was due to this. She had passed the clerical

tests given by the psychologist, showing that she was capable of the work. There might be a definite physical difficulty. Through an ear, nose, and throat examination, for which we also made direct arrangements with the doctor in the ear, nose, and throat clinic, there being no general medical social worker at the time, we learned that the patient had a 50 per cent hearing defect in both ears—"chronic discharge with accompanying impairment of nerve of hearing. Chronic pharyngitis and ethmoiditis." Occasional inflation was recommended, but it was not felt that the hearing would improve. Clearly, this was very important in relation to the patient's vocational placement. Hence we knew that there was a definite physical handicap associated with a possible psychiatric difficulty in the way of Bessie's consistently getting what was said to her by others. Practically, it meant that we no longer tried to place Bessie where she would have to take dictation.

In conclusion the following may be said in regard to Bessie: Despite the deviations from the normal that have been pointed out in this girl's case, she is one who generally makes a good impression. Her physical appearance varies, but for the most part she is characterized as being attractive. She fits in many situations as does the average girl. Her alertness varies with her adjustment. She has given the impression of being happiest when she has been employed.

The treatment, in this particular case, is still primarily psychiatric social treatment. Without such supervision the psychiatrist does not believe that the patient could avoid becoming a state-hospital case. After eight months Bessie agreed that she would like to see the doctor again and she reports occasionally now, although no intensive psychotherapy is being given. At the present time the psychiatrist feels that Bessie's negativism has decreased, that she is less shut-in. Hatred toward her parents has diminished and evident social contacts have been made. He states that if the patient can be carried over this critical period by the psychiatric social worker until psychotherapy can again be instituted, a permanent adjustment may be made.

Bessie shows something of her own present attitude by volunteering enthusiastically, "They all like me at the shop, and Miss King says I am doing very well."

Any number of cases may be found where there are interesting considerations of physical with psychiatric aspects:

Mrs. R. gradually recovers from a severe depression with suicidal ideas, as she gets over a secondary anæmia.

Louis, nearly four years old, was negativistic and a problem at table, while being dressed, and at bedtime. During the first three months of treatment, the psychiatrist referred the boy to the asthma clinic for a cough and to the X-ray department for a picture of the thymus. Medication in relation to night terrors was also prescribed.

Rose, aged twenty-four years, restricts her activities out of proportion to the recommendations in the cardiac clinic, and so uses a heart condition unduly to gain attention.

Mary at eight years of age showed excessive temper tantrums to the extent of biting herself when in the pediatrics clinic. Restlessness, loss of appetite, bed-wetting, headaches, frequent urination, and temper, all needed study from the psychiatric as well as the general medical angle. In this particular case reduction in environmental pressure had therapeutic results. All the other symptoms thus removed, nausea and headaches still remain a medical problem. This child showed undue sensitiveness to environmental change because of inherited instability due to some physical condition.

At Michael Reese Dispensary the mental-hygiene clinics have felt in particular the influence of the interest of certain general medical social workers who have a knowledge of psychiatric conditions. They have called symptoms to the attention of physicians, which has meant that patients were referred to our clinics. The worker in the children's hospital, for example, has had the chance of observing children on the wards over a period of time, an opportunity often denied persons in the psychiatric field, because of lack of hospital beds or any other provision for the controlled observation of children with psychiatric difficulties. This worker has effected a reference of cases to the dispensary mental-hygiene clinic after discharge. Getting cases for treatment as soon as possible is the aim in psychiatry, and the general medical social worker can do a great deal in the way of intercepting incipient cases, whether they be among children or adults. In fact, she often paves the way for the development of a psychiatric social-service department. When there is a psychiatrist interested in securing such a department, the way is simple for further development.

The national vocational service for the placement of psychiatric social workers has done comparatively little since 1924 in the way of placing workers in such medical centers. Few requests have been received in proportion to the fifty-five institutions that are known to have psychiatrists. Are dispensaries satisfied with personnel less well qualified, so far as training and experience are concerned, than those demanded by independent psychiatric clinics? Trained psychiatric social workers are apparently not seeking positions in general medical dispensaries. Why is this? Should the general medical dispensary not be one of the most desirable centers of work? Whatever the situation is at present, it is undoubtedly true that there will be an increasing number of satisfactory opportunities for the psychiatric social worker in the general medical dispensary as psychiatry and general medicine become a more unified service. By their very presence in these dispensaries, such workers undoubtedly help toward this end.

CONCLUSION

Psychiatric units in general medical dispensaries need the same personnel as those located in other places in the community. Here as elsewhere case-work forms the foundation for all the services performed by the psychiatric social worker. Increased opportunities for satisfactory psychiatric social work in general medical dispensaries will undoubtedly follow hand in hand with the more complete integration of general medicine with psychiatry. Departments located in such centers may offer particular advantages to the psychiatric social worker.

PSYCHIATRIC SOCIAL WORK AND THE COLLEGE STUDENT; A FORECAST

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DURING the last few years the college student has been the target of many articles by mental hygienists. In a limited way some of the various mental-hygiene programs suggested are being adopted by a few colleges. The demonstration at Yale University by the Commonwealth Fund will undoubtedly develop a complete program. However, in all of the programs thus far published, there is no social work, even though it is admittedly a necessary part of all mental-hygiene clinics and there is a greater demand for than supply of psychiatric social workers. Why is this important third of the mental-hygiene trinity, to use Southard's term,[1] omitted? Psychiatry and psychology are mentioned favorably and urged upon the college student. What is the matter with the psychiatric social worker and her art that she is not also recommended?[2] Some people reply that she is a woman and will not fit into a man's college. Others fear her upsetting effect upon deans and college presidents. "Mental hygiene is new", they say, "and must be slowly introduced into an educational system. There are prejudices against social work, as such, and it would be better to have it come in slowly after the psychiatrist has been accepted. Hence when she is introduced at all into an institution of learning, she must come in by

[1] *The Kingdom of Evils*, by E. E. Southard, M.D., and Mary C. Jarrett. New York: The Macmillan Company, 1922.

[2] EDITOR'S NOTE: The personnel of the mental-hygiene program planned for Yale University has included from the beginning the psychiatric social worker. During the first year of organization, a psychiatric social worker was employed upon part time. Beginning with the present school year, a psychiatric social worker on full time has been added to the staff. While certain functions clearly fall to her, the extension of these functions, and the integration of her work with the work of the university, will constitute an important part of the experiment at Yale.

the back way and under the guise of another title such as aide or student counselor." Must the college student be deprived of a complete mental-hygiene service because of these fears and hesitations?

Although I am a woman, also a psychiatric social worker, and therefore presumably a prejudiced expert grinding my professional ax, I am not interested in quibbling over the term by which the psychiatric social worker shall be called or in insisting that the fact that all psychiatric social workers at the present time are women does not make any difference. It does make a big difference of course, and it is bound to be a handicap in a man's university.

The essential question is, What can psychiatric social work contribute to the mental hygiene of the college student? Of course at present only predictions based on experience in other spheres of contact can be made, since no psychiatric social work has been carried on in any college.

The psychiatric social worker's functions in general are to assist the psychiatrist in his study of personality by securing data on social behavior and to assist in the social adjustment of individuals. This simple-sounding statement really means the application of a knowledge of psychiatry, sociology, psychology, anthropology, philosophy, ethics, mental hygiene, and technique of psychiatric social case-work to each individual and his environment in the practice of psychiatric social work.

The problems of adjustment in a college environment are different from those in the school or the community. A careful study of this environment must be made by the social worker if she is to be of assistance to the student and the psychiatrist. She must know what the trends of thought and feeling are among the various college groups and the interrelations between these groups. She must be able to see the elements lacking in the environment and work with the college forces to supply them. In other words, she must pioneer in this new sociologic field in a creative fashion just as she has done and is doing in the community.

In a recent article [1] the difficulties of getting a complete

[1] *The Administration of Mental Hygiene in Colleges*, by Florence Meredith, M.D., MENTAL HYGIENE, Vol. 11, pp. 241–52, April, 1927.

picture of the student is stressed. In the gathering of social data the aim of the psychiatric social worker is to obtain as full a picture of the student as possible from all who know him well, to evaluate the past or present social trends in his life and the prejudices of the people who give the history, and to indicate his social shortcomings and resources. This is all a definite part of the psychiatric social worker's job. The only difficulty in this phase of her work that she would encounter in a college more frequently than in the community is the distance of the student's family from the college. This can be overcome by correspondence and in some instances by traveling to the home or having the parents come to the college.

At this suggestion I can feel arising all the fears of the official college world against contact with parents by any one but the deans or president. Of course any such contact must be officially correct and must be of such a nature as to improve the student's social situation, not harm it. The art of approaching individuals in a family group and elsewhere for the purpose of getting data on behavior and helping in social adjustments is one in which the psychiatric social worker is skilled through long training and practice. She must be trusted as an expert in this field, just as the psychiatrist is trusted in his personality studies of individuals.

The biggest contribution that the psychiatric social worker makes in her clinical work is the assistance to the student in making his adjustment. All the other work she does is to facilitate this. Typical social problems of high-school students which might be paralleled in college are the student who is failing in class because of too much recreational activity, the socially unsuccessful student, the lonely student, the one who worries over his future vocation, the over-ambitious one. All these and many others can be helped by the psychiatric social worker who will interpret the psychiatrist's findings to the instructors and to others who are helping him, advise with them on ways and means of readjusting class work, recreation, and so forth, and keep in touch with the student, having him report back to the psychiatrist whenever it seems to her advisable. She will not remove the social supervision of the student from the student adviser, but will work with them

both, thereby strengthening the natural contacts of the student and educating the adviser in psychiatric social-work technique. In some instances, of course, complete control of the supervision will be kept by the psychiatric social worker for a time until the student is well enough to be under less specialized care.

The technical skill of the psychiatric social worker has been described elsewhere. It is the art by which, in conjunction with the psychiatrist, she deals constructively and objectively with individuals in helping them realize themselves as social beings. By means of her technique she brings mental hygiene practically into their lives as a motivating power. The best methods to use with students in a college environment will have to be evolved by her within the college as an important part of her research.

The position of the psychiatric social worker in the college will of necessity be that of a liaison officer between the various social forces, the extra-curricular activities, deans, personnel department, recreation, student organizations, and the student and psychiatrist. Her academic contacts as such will be with the departments of sociology and psychology as a means of getting advice and assistance in carrying out research projects. Research should be an integral part of this new application of psychiatric social work for years to come and should not be lost sight of under stress of numbers and emergencies.

Another important contribution of the psychiatric social worker in college is in vocational advisement in relation to the field of mental hygiene. This is not a new departure. Pre-vocational visits of a week or longer during vacation periods have been planned for undergraduate students by psychiatric social workers in community clinics for a number of years. The most recent systematic effort has been that of the Chicago Round Table of Psychiatric Social Workers, which organized observation trips to two local mental-hygiene clinics during vacation periods in 1926–1927. Contacts were made with five colleges and a total of twenty-seven students responded, ten of them men. Each trip was concluded with an experience meeting and a discussion of the vocational possi-

bilities and requirements of the professions of psychiatric social work, psychiatry, and psychology. In various universities undergraduate students in sociology get some pre-vocational work in mental-hygiene clinics and have lectures by psychiatric social workers. Such opportunities as these could be fostered by the psychiatric social worker on the mental-hygiene staff of the college and should be an integral part of her work.

These, then, are in general the functions of the psychiatric social worker as they might be carried out in a college: (1) case-work with the student, including both gathering the history of his behavior and assistance in his social adjustment; (2) organization of social resources to help the student in his social adjustment; (3) training of student advisers in the technique of applying mental hygiene; (4) liaison between the student, the psychiatrist, and extra-curricular officials and activities; (5) pre-vocational education and advice in relation to the field of mental hygiene; (6) research in the sociological and technical phases of psychiatric social work.

The practical difficulties of carrying out these aims have been touched on in part. The initiative and invention of the psychiatric social worker will be taxed to meet them all, but her training develops just such qualities. Psychiatric social workers have worked successfully in veterans' hospitals. They have overcome many problems and prejudices in communities and institutions of many kinds. One with social vision, greatness of spirit, poise, good training, and sufficient experience should be able to carry out these six functions adequately and to overcome obstacles easily. Her professional activities are unique and cannot be carried out satisfactorily or wisely except by such a trained expert.

MANIFESTATIONS OF MENTAL DISORDERS IN TRAVELERS AID SOCIETY CLIENTS *

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MY INTEREST in the Travelers Aid Society was aroused a year ago, when I was asked to examine some of the clients of the New York society who needed a psychiatric survey. Because of lack of time, I was at first reluctant to accept this invitation. But when I went to the Travelers Aid Society Guest House in the heart of New York City and saw the large number of human beings who needed help, I recognized what an unusual opportunity was offered, not only to be of service, but to study a wealth of extremely interesting material. The Guest House receives travelers of all races, creeds, and colors; one finds there a veritable cross section of humanity. I was impressed, in my work there, by the inexhaustible stream of human suffering that flows through its doors, and I was still further impressed by the splendid service that the society is rendering, seeking no reward save that of having its hospitality and assistance accepted. The ramifications of the society in every part of the country make it possible to secure thorough histories in a very brief period of time, and the exhaustive studies made of each case result in the collection of case histories that have proven very valuable in psychiatric and sociologic studies.

With this brief introduction, I will refer specifically to the mental disorders of certain clients of the society who have come under my observation.

Case I.—Alice L., an attractive girl of twelve years, was brought by a conductor to a representative of the Travelers Aid Society at the Grand Central Station, where she asked for assistance in locating a friend who was supposed to meet her. After waiting for the friend for a reasonable length

* Read at the annual conference of the National Association of Travelers Aid Societies, Des Moines, May 12, 1927.

of time, she was brought to the Guest House. When interviewed, she told a very plausible and quite appealing story. She said that she was born in Germany, and had been brought to this country five years before after the death of her mother. Her father had remarried and made his home in Chicago. The stepmother was very unkind to her, and would frequently beat her. The father also mistreated her.

Alice was a lovable child who won the sympathy and friendship of most of the workers in the Guest House. But all the addresses that she gave proved to be fictitious. When confronted with the returned telegrams, she would give another address, which would in turn prove fictitious. She was, however, always able to offer reasonable excuses, and she would apologize very cleverly for having made a mistake.

After she had been in the Guest House for a week, she was referred to me for examination. I then made the following note:

> "Physically, the traveler is unusually well developed for her age. She is of superior intelligence mentally, and shows good home training and discipline. She is not telling a true story. She is making much of the situation, playing the rôle of a heroine and getting a good deal of fun out of the hide-and-seek game she is playing. She is abusing the hospitality of the Guest House. She is of the so-called 'hysterical type'."

After my examination, Alice admitted that she had been untruthful regarding her residence in Chicago. The addresses that she had given were former residences, which accounted for her familiarity with locations and so forth. As soon as she gave her correct address, her parents were located, and they sent funds for her return home. She was placed on a train and started for Chicago, but got off the train in Toledo, and went back to Cleveland, where she again fell into the hands of the Travelers Aid Society. Her father then went to Cleveland for her and brought her home. A report from Chicago says:

> "Although Mrs. L. is Alice's stepmother, she gave every indication of feeling very badly and greatly worried over Alice's actions. We do not believe that she is unkind to Alice, but it may be that she lacks knowledge and understanding of the child. We learned from a conference with a minister, a friend of the family's, that this is the third time within the past month that Alice has run away. She did not get

any distance the other times, however, as the minister succeeded in locating her with friends and returned her to her parents.

"The minister told us that Alice naturally has a love for the finer things of life and is very much discontented with her own home surroundings, considering her stepmother old-fashioned. At one time Alice entered a department store in the neighborhood and ordered a dress and sweater coat, charging them to a friend. The manager became suspicious and refused to let her have the articles. When confronted with his accusation, she told a wild story of being ordered by bandits to enter the store to secure the articles. When she returned from one of her little runaway trips, she had with her a pair of stockings which she had stolen from a department store. The parents believe that this escapade was due to the fact that she had been reprimanded for taking a history book from one of the other children in school. She took it and insisted that it belonged to her. Mr. L. told us that once when he had just been paid and had the money in a small suit case which he had locked very securely, Alice obtained the key and took $35. Mrs. L. admitted that they had threatened to place Alice in an institution if she continued in these actions.

"We have every assurance, however, that the stepmother has not mistreated the child; on the contrary, she has a great love for her. But Alice is not truthful, very precocious, and certainly needs more attention than her parents can give her. She can invent stories very rapidly, and, as has been proven to you, will tell the same story consistently without arousing any suspicion that she is not telling the truth."

A later report from Chicago states:

"Alice's case is now in the hands of the juvenile court, and their representative has visited the home several times. Alice has returned to school, very proud of her runaway experiences and feeling that she is quite a heroine."

The society in Cleveland reports on Alice as follows:

"We are still unable to understand how Alice got off the train at Toledo and back on another train to Cleveland without having been stopped by some one in authority. The conductor who brought her to our T. A. S. desk said that he had found her in the washroom without a ticket when he went through to collect fares; that she had told him that her mother was visiting a German lady in a compartment, but that they could not find her. Alice had cried and been comforted by passengers. She had finally decided that her mother, who had, she said, got off the train at Toledo for a magazine, had been left behind.

"After definite identification had been made, Alice was given a pencil and a writing tablet and told to write what she had done on the three days of the last week. She wrote several pages, giving no reason for her recent escapade other than to illustrate her unusual aptitude as a fabricator."

This case is a vivid illustration of conduct disorder in a child. Alice is obviously of a neurotic constitution and is a

potential menace unless she is given expert guidance by those who understand the inherent defects in her personality make-up. Individuals of this type, because of their lack of poise and their great craving for approbation and attention, often stop at nothing to secure their ends. The hysterical child has more than once disrupted a home or even sent its parents to jail because of some wild tale of torture supposed to have been inflicted upon it. The trained psychiatrist should readily detect this type of conduct disorder.

Case II.—Mary B., aged fourteen years, stated, when interviewed, that she was eighteen years of age, that her home was in Pittsburgh, and that she had come to New York to visit friends, but could not locate them. She repeatedly contradicted herself in her statements, and when this was called to her attention, did not seem to be at all disturbed by it. Her physical examination showed irregular pupils with irregular pulse and unequal reflexes. There was considerable irritability and some impulsiveness. We therefore decided that this girl at one time had had epidemic encephalitis (so-called "sleeping sickness").

Her mother came to the Guest House and identified the child, giving the following history:

Mary was well until January, 1922, when she contracted sleeping sickness. She apparently made a satisfactory recovery from the acute phase of the infection. In July, 1922, her mother gave her a five-dollar bill to purchase some silk thread. She failed to return from the errand and on the following day was brought home by an old lady who had found her wandering aimlessly about the streets. She claimed that she had lost the money. Since then her conduct has been quite abnormal. She has been helping herself to small change from any one with whom she comes in contact. In December, 1924, she was brought to the psychopathic ward of a general hospital where she remained for several weeks. She was then returned home, but again acted very impulsively and at times excitedly. In April, 1925, she was committed to a state hospital, from which she was paroled in October of the same year. Her conduct has since been very unsatisfactory. She has been excited at times and very impulsive, running after boys and staying away from home repeatedly.

This child is one of the many children who have recovered from the acute phase of lethargic encephalitis. This disease causes definite structural changes in the brain of its victims. When they recover from the acute phase, many of them enter into one of the many peculiar states that are now collectively designated by the term "post-epidemic-encephalitis reactions". The children who have had this illness often show a profound change in behavior. They become impulsive, excitable, and precocious sexually, and manifest many delinquent traits. The vast majority of them need treatment in mental hospitals.

We have had another group of children from eight to fourteen years of age who were in excellent physical condition and of normal or even of superior intelligence. They were brought to us from other cities and from railways. These youngsters presented a common problem—namely, an unfavorable home environment. They did not receive the proper care and training at home, and were permitted to shift for themselves at a very tender age. Some came from homes in which there was marital unhappiness and discord, and they were denied the natural spiritual stimulation derived from happy parents. Others had widowed mothers who had to work during the day to maintain their homes and could not give the children the necessary care and attention. A few came from homes of too many children, none of whom apparently were receiving the necessary attention. Others, again, came from families who maintained very strict discipline from which the children tried to escape. A small number were forced to earn money to supplement the family budget and were stranded on their way from their work. There was, again, a fairly large group who showed an unusual initiative and aggressiveness which enabled them to become leaders of the children in their neighborhoods. Many of these undertook trips to other cities, especially to those that were conducting expositions, such as the Sesquicentennial at Philadelphia. All of these youngsters required special guidance, and a number of them were referred to various agencies dealing with juvenile problems.

Adolescence is a very delicate stage in development, especially so to an individual of unstable nervous make-up.

At this time of life there is a marked activity of the glands of internal secretion, which, if functioning incorrectly, may cause definite conduct disorders. The sexual development at this stage, too, may be fraught with considerable danger. Modern civilization, with its suggestive literature, stimulating movies, and exciting tabloid newspapers, may cause hypersensitivity of the various emotional and physical reflex arcs that make up the psychosexuality of the individual and play havoc with his mental life. Marked emotional crises may occur during this period, varying from mere transitory crying spells or periods of depression to irritability and resistance to all authority. Various forms of indiscreet sexual activities may be indulged in, and unhealthy associations and friendships formed. Many of the serious psychoses begin to manifest themselves at this time. It is therefore very important that clients who are in the adolescent period should receive a thorough psychiatric survey in order that they may secure the fullest benefit from their association with the Travelers Aid Society. The following cases are illustrative of some of the problems presented by adolescents.

Case III.—Edith M. was brought to the Guest House by a worker of the Travelers Aid Society. She had come to the society's desk at the Grand Central Station asking for assistance in securing employment. She seemed worried, and was brought to the Guest House for further observation. As she could not give a coherent story, I was asked to see her.

She stated that she was born in Fall River, Massachusetts, in 1909. There was one sister younger than herself. The father worked in a car barn, and the mother did housework. The client claimed to have attended day high school for one year and evening high school for three years. When asked her reason for coming to New York, she at first evaded the issue and would not give a frank account of herself. Upon being encouraged to reveal her difficulties, as otherwise we could not be of help to her, she burst into tears and told the following story:

Her parents were ignorant and unkindly disposed toward each other. She was never permitted to go out with girl friends nor was she allowed to continue her studies at high school. When she entered evening high school, her

mother frequently refused to let her go to class. Although she did all the housework, she was never given any spending money. At sixteen years of age, she made the acquaintance of some high-school boys and soon accepted invitations to ride in their automobiles.

In February, 1926, she found that she was pregnant. The young man took her to a woman who performed an abortion on her. Septicæmia developed, and she was taken to a hospital where she remained for two weeks. She would not disclose the name of the woman who had performed the abortion. She was then put under the custody of a children's society and was told to leave her home town and seek employment in another city. A position was secured for her as a domestic in which she received seven dollars a week. The agent of the society supervised all of her activities; she was not permitted to spend any money without the agent's permission, nor was she allowed to seek ordinary diversions. She therefore decided to run away and come to New York.

Edith was a bright girl, physically quite attractive. In her home life she was denied the natural affection and stimulation that a highly intelligent and emotionally rich adolescent requires, and when temptation came her way, she succumbed, not because she was inherently weak, but, as she said, because "the young man was so kind and apparently considerate and lovable". Her character is revealed by her refusal to disclose the name of the woman who performed the abortion on her.

She expressed a desire to enter a nursing school and become a trained nurse and I was inclined to believe her story and to assist her in entering a training school for nurses. I personally regarded her as a girl who had ideals, but who had fallen under the stress of environmental situations. However, a telegram was received from the children's society that had the custody of the girl instructing us to return her to them immediately. Their request was complied with.

Case IV.—Grace W. first came to the Travelers Aid Society in April, 1927, asking for assistance in securing a position. She was sent to a home on Morningside Drive where she was immediately employed to do housework. Shortly afterward she returned to the society announcing that she

could not remain there any longer as the mistress of the house had made homosexual advances to her. The girl appeared quite worried and unstable, and asked one of the workers how she might become a Jewess.

She was taken to the Guest House, where she immediately applied herself assiduously to any duty assigned to her. Her conduct was so unusual that I was asked to see her. After a rather prolonged interview she told the following story:

She was born in 1908 in a city in the Middle West, of Lithuanian parents. She is the youngest of a family of three. Her father was a laborer and her mother, an ignorant woman, was unaccustomed to the ways of her adopted country. At thirteen years of age, our client had to go to work. She had had, however, one year of country high-school education, and succeeded in securing a position in the home of a Jewish physician in Chicago, apparently a man of excellent professional and ethical standing. She soon was asked to assist him in his laboratory and proved to be a very efficient worker. Both the physician and his wife took a kindly interest in her. They taught her the value of caring for her health, both of mind and body. She was permitted to use their library, and soon gained an acquaintance with good literature.

She gradually became greatly attached to the physician. She adored him—as she put it, worshipped him. Apparently he was a man of deep religious convictions, and on the Sabbath Day it was his custom to read the scriptures to the family. Grace soon absorbed the Jewish faith—in fact, would join the family circle in prayer.

She remained in this home for two years, when the physician was offered a professorship in a medical school in a Western state, which he accepted. When the family left, Grace was asked to go with them, but she felt that she had grown to love her employer and that it would hardly be wise to continue to be in close proximity to him. She therefore did not accept their invitation. For three months she tried various positions, but was not contented and finally came to New York, hoping that she might secure satisfying work here.

Grace was very bright and alert and showed rapid ideation. She was emotionally tense and gave evidences of a tendency toward mood fluctuation. She spoke very good English. She

was apparently missing the sympathy and attention that the physician and his family had given her, and her request for further information regarding the Jewish faith was simply a rationalization of her devotion to the physician and a substitution of her feeling for him.

Her problems were frankly discussed with her, and she admitted that she was in love with the physician. She expressed a desire to take up nursing as a career, and I thought it an excellent plan. She was taken to a hospital and interviewed by the superintendent of nurses, who proved very coöperative and was apparently greatly taken with the girl. Grace and the worker of the Travelers Aid Society were shown through the hospital, and Grace was much impressed by it. She was accepted as an attendant, receiving $40 a month and maintenance. Arrangements were made to have her admitted to the training course in the September class. In the meantime she could attend school and make up the extra credits that she lacked for admission to the training school. Grace was quite happy with the arrangement and immediately began work in the hospital. I believe that she will eventually succeed in her undertaking. A worker from the Travelers Aid Society will be in touch with her and will lend a helping hand whenever necessary.

The problems of the adolescent often mirror the general state of tension and unhappiness in the home. No member of any family can act without in some way influencing other members of the family. Hence, whenever a serious conduct disorder is shown by any member of the family, it is fairly safe to conclude that the general atmosphere of the home is such as to influence others unfavorably. The following case illustrates this point:

Case V.—Our client, aged sixteen years, was stranded in Philadelphia on a visit to the Sesquicentennial. She was assisted by the Travelers Aid Society to return to her home in New York. Her physical appearance and her general behavior interested the worker of the society, and she advised the girl to come to the Guest House for an interview with me. I not only saw her, but interviewed her parents also, eliciting the following history:

The client is the youngest of a family of three. The older

sister and brother are attending college. The father is a bookkeeper. The mother is apparently intelligent, but seems to be very tense emotionally. The client, now in high school, is unusually bright, with an I.Q. of 120. She had been progressing well at school until two years ago, when she began to grow unusually stout. She also became irritable and impulsive and neglected her school work. The home environment was apparently good, but lacked religious training. The family was Jewish and lived in a Jewish neighborhood, and yet had no religious affiliation.

On examination the girl presented a typical endocrinological disorder, showing definite hypopituitarism with compensatory hyperthyroidism. Mentally, she was lively, decidedly distractible, and at times flighty and irritable and of a hypomanic personality. She accounted for her trip to Philadelphia by saying that she had been "dared to go" by a friend who accompanied her. We advised that she be taken to a neurological clinic for further study and observation.

Two days later I met her father, who told me a rather interesting story. His salary was such as barely to furnish the necessities for his family during the period of the high cost of living. He lived in a good neighborhood and saw his neighbors' families enjoying luxuries that he was unable to give his own family. This caused a feeling of inferiority in him. His wife, too, who apparently dominated the home situation, was unhappy because of his failure to support his family according to the neighborhood standards. Moreover, since the children could not be given luxuries, they were permitted privileges in other directions. The father felt that he had no right to restrain them in any way. He told me that he would not take his daughter to the clinic to which I had sent her because he feared his neighbors might learn that he had had to resort to charity. As he could not afford private expert neurological care, he had her sent to a distant clinic.

The Travelers Aid Society worker got in touch with a teacher in the high school in which our client was a pupil. It was learned that she was regularly attending the neurological clinic and was receiving pituitary-gland extract with considerable benefit. She had grown four inches in height in

four months, and her mother reported that for the first time she was able to buy ready-made clothing for her. Her work in school improved considerably, and she found a social outlet by joining the high-school glee club. There one of the other members became very much interested in her and asked her to join the choir of an Episcopalian church. She accepted and shortly afterwards began to talk of joining the church. This was bitterly opposed by her family, with the result that she ceased to speak of it and simply went her own way. When asked what she hoped to gain by joining the church, she replied, "Oh, comfort. I like to know that there is a God when I am feeling bitter. I seek peace of mind. The people at church are nice; they don't holler at you." She finally joined the church and seemed very happy about it. She was expecting a great storm when the family should learn about it, but said that she did not care.

She had had an affair with a married man and explained her attachment to him by his kindness to her. The affair was successfully broken off by the high-school teacher who was interested in her.

Handicapped by an endocrinological disorder, deprived of the outlet that religion offers to emotionally rich people, and living in a home atmosphere where there was considerable tension, our client reacted in the manner outlined above. It is interesting to note that her brother, who had attended the same high school, also showed evidences of an unstable personality.

We are constantly receiving young girls of from fifteen to twenty years of age who come from rural districts, and who, though native born, are the children of immigrants who still retain the customs of their native lands. These adolescent girls have relatively little in common with their parents. They are strictly supervised at home, not being given the liberties accorded to native children, and as soon as they are able to take care of themselves, they leave home and usually seek employment in some large city. Some of them are quite intelligent, and readily secure employment. Others are somewhat defective intellectually, and have to be assisted in securing work. Many of them have become sophisticated, usu-

ally through the associations that they make in their efforts to escape unsympathetic home conditions.

Amongst the most difficult cases that we encounter are the feebleminded. These people, because of their low native intelligence, are unable to plan for the future, or to resist the temptations that come their way. Usually they are between eighteen and twenty-five years of age. Many of them are physically quite attractive, in which event they invariably admit sex promiscuity. A few of them have been openly practicing "Mrs. Warren's profession", and have come to New York in the company of some man who later deserted them. Some of these mental defectives have contracted marriages with men much older than themselves and have deserted their homes, eloping with younger men.

It takes considerable judgment and experience to know how best to advise these clients. They are, as a rule, unreliable. When a position is secured for them, they hardly ever hold it for more than a few weeks. Our policy has been to advise their return to their homes, or at least to the communities from which they have come. Occasionally we are in receipt of a request from some minister or town official urging that a particular mentally defective client be retained in New York City, as she is an undesirable citizen in her home town. It would be interesting to know what these ministers and public officials think of New York when they urge that the riffraff of their own communities be dumped there. From a scientific point of view, mentally defective people are more apt to make a successful adaptation to the simple life of a rural community than to the highly complicated life of a large city.

We have also encountered a group of foreign girls who have come to this country in the hope of marrying men with whom they have been corresponding. They make the acquaintance of these men through a matrimonial agency or through advertisements in newspapers, and upon meeting them, find that they are either married or, if single, are entirely different from what they appeared to be in their correspondence. As a rule, these women are of peculiar mental make-up. Some of them are of border-line intelligence. Others are of the sensitive, introverted, retiring type, and unable to compete with

the girls of their own country, they gladly accepted the opportunity of meeting some man, even though of another country. These clients are best served by returning them to their own homes. It is entirely too much to expect them to make an adaptation in a new environment in face of their handicapped personalities.

Not a few of our clients have shown more serious disorders than those mentioned above. Many of them are definitely psychotic. Of these, those between the ages of twenty-five and fifty years usually suffer either from manic-depressive psychosis or dementia praecox, those over fifty from cerebral arteriosclerosis or senile psychosis.

In manic-depressive psychosis, there is a marked change in the mood, ideation, and motor activity of the individual. The manic phase is usually characterized by overactivity, restlessness, irritability, rapid ideation, and elation. When this occurs, the individual is constantly on the go, cannot tolerate routine work, is impulsive and irritable, and will often leave home. Thus, one of our clients, a woman of forty years, came from a small town in the Middle West, bringing with her four young children. She was quite boisterous on the train and when she got to New York, the conductor referred her to the Travelers Aid Society desk. When I examined her, she showed all the signs of a mild, but definite manic-depressive psychosis. She was referred to the observation ward at Bellevue Hospital, and from there was deported to her home.

Not a few of those in the manic phase of manic-depressive psychosis at the beginning of their illness become intensely erotic, and may commit serious sexual indiscretions. They may elope with men, only to be deserted on the train or in a hotel.

Individuals in the depressed phase of manic-depressive psychosis find it very hard to think, as ideas come to them very slowly. They are moody and down-hearted and have feelings of inability to cope with the problems that confront them. They become obsessed with the idea that they are burdens to themselves and to their families, and may leave their homes with the idea of relieving their families of this burden. These people are suicidal. In fact, most of the

suicides belong to this group of mentally sick people. We have had a few clients who were suffering from this mental disease. One of them, after being committed to a state institution, committed suicide there.

Dementia praecox is a chronic incurable mental disease, characterized by delusions and hallucinations and by persecutory ideas. We have had a large number of clients with this disorder. Many of them had left their homes in their efforts to escape their imaginary enemies. Some came to New York in response to imaginary commands and orders, received from some supernatural source. Others had some mission given to them by the Lord. These clients, as well as those suffering from manic-depressive psychoses, are best served by being sent to the observation ward at Bellevue Hospital, where they can be carefully examined, committed to state hospitals, or transferred to their native towns.

There is another group of people suffering from a chronic mental disorder known as paranoia. This disorder is characterized by well-systematized delusional formations based upon false premises. The thinking processes of these individuals are logical and coherent and their personalities are well preserved. They often come from cultured and refined homes, and their stories are so plausible as to win sympathy and friendship. They are shrewd and very resourceful, and are hardly ever committed to institutions for mental diseases because of the excellent impression they make upon juries and committing judges. They will enlist many influential people as champions of their cause. They usually come to such an organization as the Travelers Aid Society for help of some kind, and it requires considerable experience with mentally diseased people to recognize the true nature of their disorder. They are quite cunning, and quick to perceive when the true nature of their disorder is detected. They will then turn upon the one who understands their illness and involve him in their delusional formations. Whenever such a patient is detected by the Travelers Aid Society, it is advisable to communicate immediately with the nearest relatives and urge them to take the client into their own care. If that is not feasible, it may be best to take a passive attitude

toward the client, as to urge admission to a psychopathic ward may lead to many legal complications.

To illustrate, Mrs. F., aged fifty, came to the Travelers Aid Society asking for temporary lodging. Her behavior was so unusual that I was asked to examine her. She spoke quietly, relevantly, and coherently. She came, she stated, from old stock that had achieved eminence in industrial and political fields. She had married a college graduate who was very well situated financially and socially. Three children were born to them. Then the husband died. The client claimed that an unmarried sister had swindled her of all her money and taken her children and would have nothing to do with her, refusing even to see her. The client had kept insisting that the sister return her children and her money and the sister had had her committed to the observation ward of Bellevue Hospital. According to our client, she was discharged from the observation as sane.

The sister was communicated with, and a history of the client's case was obtained from Bellevue Hospital. It was then learned that the client had been diagnosed as a case of paranoia, but the judge would not commit her to a hospital for mental diseases. It was learned that after her husband's death, the client had spent her money lavishly, and had mistreated her children. The sister then had stepped in and taken the children from her, and also had had her declared an unsuitable guardian for her children.

The various lawyers who had had the client's case were interviewed, and it was learned that they had dropped her case because they regarded her as a "queer woman", though not definitely psychotic. Moreover, she had squandered all her money, and they would not take her case without a fee. Some of the lawyers interviewed admitted that a wrong might have been done to the client, but stated that there were too many people involved who were of high social standing and of political power.

It became obvious that there were so many legal complications that it would be unwise to take too active a part in advising the client as to her proper course of action. Money was obtained from the sister and given to the client, who

finally left the Guest House, grateful for the kindness and attention shown her.

The mental disorders that manifest themselves after fifty years of age are usually caused by definite structural changes in the brain. The most serious ones are those due to cerebral arteriosclerosis, hardening of the arteries of the brain, and to breaking down of the brain cells themselves, causing senile deterioration. Many of these people become so deteriorated intellectually as to be decidedly psychotic. They become irritable, forgetful, and show marked memory defects. Some of them become confused and wander away from their homes. Many of them may even express delusions and ideas of persecution. Almost all of them, particularly those suffering from cerebral arteriosclerosis, will show concomitant physical disorders, such as general arteriosclerosis or heart and kidney disease. These people are frequently brought to the Travelers Aid Society agencies with the request that they be assisted in locating their relatives. Many of them require observation in a psychopathic ward. A few are located by their frantic relatives, who have been looking for them all over the country.

We have had also a group of old people who came to this country at an early age and who, after leading a more or less unhappy, nomadic existence, finally decide to return to their people in their native land. Some of them may have not enough money to enable them to defray the costs of passage; others are too old and feeble to stand the trip; a few are decidedly in need of hospital care and treatment. Valuable service may be rendered these people by helping them to secure either the necessary passage or hospital care and treatment.

Pathetic pictures are occasionally presented by clients who are of sound mind, but of sick body. Thus the very first patient that came under my observation at the Guest House was a woman suffering from Huntington's chorea. She was returning from the South to her home in New England and had lost her purse with her railway ticket in it. Because of the involuntary movements of her limbs and the indistinctness of her speech, she was taken to the Travelers Aid Society desk at the station. When I spoke to her, and she

realized that I understood her ailment, her confidence was immediately gained and she gave the address of her people. They were notified of her plight, and telegraphed money to her. She left grateful for the help given her.

Another client whom I examined, a man of fifty-five years, was born in Maine. His parents had married when the father was but twenty and the mother sixteen. Marital unhappiness, separation, and finally a divorce had resulted. Thereafter our client had had to shift for himself without parental guidance. He had finally landed in San Francisco, where he had worked as a cook. The greater part of his life had been spent as a cook in lumber camps and on the estates of large land owners. During the last three years he had been ailing with heart trouble, which at times incapacitated him.

He had not seen his father for thirty years, but he had recently learned that his father was still alive, and had come to New York to visit him. He located him in a tuberculosis sanitarium. Our client then had tried to secure employment, but had become ill on the train and had gone to the desk of the Travelers Aid Society for help.

On examination, he showed the typical picture of one suffering from angina pectoris. He was of pleasing personality and obviously deserving of assistance. I recommended that he be placed in the home of a decent family where he might do cooking. According to my suggestion, a position was obtained for him in the country home of a sympathetic family. A report from his employers stated that he was doing very well, fitting in nicely with the family. It stated also that he spoke with great respect and gratitude of the assistance given him by the Travelers Aid Society.

I have tried to give you a glimpse of the mental disorders found in some of the clients whom I have examined at the Travelers Aid Society Guest House. The problems that these people present are the results of mental disease or of unfavorable environmental situations, and we have tried to deal with them according to the principles of modern psychiatry. This approach to human problems is now being utilized by progressive schools and colleges, courts, and penal institutions, as well as business organizations. It is natural that the Travelers Aid Society should also adopt it. In so doing, it will greatly increase the efficiency of its fine work.

THE PROBLEM OF MEETING THE NEEDS OF THE SOCIAL WORKER WHO REFERS CASES TO A PSYCHIATRIC CLINIC *

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THE subject discussed in this paper is of growing importance both to the social worker who seeks the services of the psychiatric clinic and to the clinic that tries to meet her needs. It is a difficult subject to discuss because as yet there has been almost no careful consideration of the common ground implied.

A glance first at existing psychiatric resources reveals marked limitations. Many of these are limitations inherent in the nature of psychiatric services, which, according to their set-up, are specially adapted to doing adult or children's work, diagnostic or treatment work. One type of problem, therefore, is more adequately handled by one clinic than by another. The social worker learns this by experience rather than through any available descriptive statements of services. A large number of clinics are attempting to do undifferentiated work, hampered by the stage of development of their particular structures. It would be difficult to say whether the quality of work and the insight into the needs of the social worker in a referring agency find greater opportunities for development in differentiated or undifferentiated work in these instances.

Specifically, there are, for instance, functional limitations inherent in the variations in staff set-up in these clinics. There are clinics with and without psychological facilities. Obviously, the psychological examination supplies important determinants in the psychiatric analysis of problems. Comparatively few clinic staffs include full-time psychiatrists. With limited psychiatric services and the usual demand for

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examinations, treatment is minimized, and where treatment is initiated, its effectiveness is greatly limited by lack of time for the analysis necessary for a real integration of findings. Psychiatrists who are working without social workers are particularly handicapped in the matter of capturing social implications and of giving the interpretation the referring social worker hopes to get. Without the combination of diagnostic and treatment experience into a conscious working relationship of all the workers on the case, it is certainly difficult to mark growth and to evaluate contributions.

If a particular staff group is not equipped by experience to do a comprehensive piece of social psychiatry, time and experience in working together are essential for the development of the requisite technique. The personnel already experienced in clinical psychology, psychiatry, and psychiatric social work is as yet a small group. At the same time the various clinics are attached to such a variety of organizations that the administrative problems of one are not the administrative problems of another. Discussion of common problems of this nature among psychiatric agencies is amazingly difficult. The majority of psychiatric clinics are maintained by larger organizations—medical, court, social, or educational—of which they are only one department. The vision and receptivity, then, of these organizations and their policy-governing bodies become factors in the developmental possibilities of the clinic. Many of these clinics have little or no contact with boards or other governing bodies. There is a certain desirable protection of the professional aspect of the work in this set-up. On the other hand, this protection is probably one of the important factors that operate to keep the clinic from realizing some of the needs of the social worker who refers cases. The experience of having constantly to interpret a technique in acceptable terms for a lay board or for professional workers in another field gives insight into working relations and other people's difficulties in seeing them.

There is a vast difference between the number of cases that can be handled on a purely diagnostic service and the number that can be handled on a service that requires really comprehensive recommendations for social adjustment. It is

natural, therefore, that the latter type of service should be far less well developed. Because of the time element involved, the financial expenditure for professional services is very high. Only under certain conditions of organization, therefore, has it been possible to develop such services with any certainty. Many psychiatric agencies have confined their efforts to particular phases of work, doing frankly only routine examinations that may determine commitment to institutions for the feebleminded, the epileptic, or the insane. This meets one of the needs of the social worker. It does not help her to handle the multitudinous mental-hygiene needs of the case load that is her responsibility in the community, and it is well recognized that adequate handling of these needs may comprise the greatest conservation for usefulness and happiness of this cross section of human material.

The greatest opportunity for development in descriptive diagnosis and adjustment process through actual work with the social forces operating has come through the clinical material in children. This is natural because adequate handling of the child's problem carries us into the heart of the family situation. The child's problem most frequently resolves itself into the parents' problems, and since the child is still in the formative stage, we are plunged into the task of adjusting adults in the very active process of normal living under normal limitations. This carries psychiatry into every known field of social adjustment and requires mutual understanding and coöperation far beyond the limits of the laboratory walls or the office interview.

In the same way the history of psychiatric social work is largely a picture of existing psychiatric resources, because the growth of psychiatric social work has been largely the growth of social psychiatry in terms of its value to the social worker, the teacher, the parent, and others. Being a very young field, it still exists in all stages of its history. Certain stages of development serve certain needs, so that there have been plateaus in psychiatric social work and further development in these areas as well as the general development in the direction of preventive work. Obviously, there is still need for the psychiatric social worker whose technique in handling resistive patients facilitates their removal from the home to

the hospital and whose knowledge of institutional facilities lubricates the machinery for obtaining care. She is still needed in institutions to insure therapeutic and recreational outlets for patients; to investigate and prepare the home setting for the returning patient; to follow up and frequently enough to recognize and avoid crises; to establish contacts that will facilitate voluntary hospital admissions and remove the stigma from treatment; to minimize fear and foster preventive measures and early diagnosis.

But the psychiatric social worker must appear to-day, in these varied forms, confusing to the social worker in other fields. The psychiatric social worker has had to evolve her rôle to meet the needs and requirements of her particular psychiatric setting, at the same time preserving her case-work technique and sufficient rapport with the development of this technique to be constantly awake to changes in the general field as well as in her specialty. She has at times lost sight of some of these objectives. She has had to respond to calls for which she was barely ready and frequently to maintain an equilibrium that was greater than her maturity. The present lack of uniformity during a period of adaptation is probably a healthy condition, so long as it is based on a standardized training background.

Because, as we have said, the well-developed children's service necessarily treats the natural- or foster-family situation as a whole, the emphasis is moved up to the base of active operations—the home. This forces the psychiatric social worker in such a clinic into active participation in the treatment process. Her every contact is necessarily part of the treatment process. Her insight into the significance of the everyday type of situation in the home, as she discusses it and observes it, determines the number of opportunities she is able to embrace on the spot and the intensiveness of the treatment accomplished. At this point, it is not easy to differentiate her work from that of the psychiatrist. At this point also, she realizes, and the psychiatrist realizes, to what extent the social worker in the referring agency is thrown into the center of the treatment process on her cases. It follows that her natural position in the family situation cannot be replaced by the psychiatric office interview, and that con-

structive supplementing of the treatment in the clinic and in the home depends upon mutual understanding of both objectives and process.

Recent developments in dynamic psychiatry open up a tremendous field. We are beginning to realize that every emotional and intellectual experience plays an important part in the development of the individual, superimposed upon his particular potentialities and limitations. Actual projection of the psychiatric technique into the environmental picture has come to mean the permeation of mental hygiene through all the fields that have to do with shaping the experience of the individual. The treatment process, therefore, enters into all contacts, and it becomes essential to interpret the psychiatric material that comprises the clinic's contribution to social workers, teachers, parents, and so forth. The clinics cannot successfully replace these factors, or work without them, and still preserve the newer concepts. So we are all faced with the task of knowing one another's fields sufficiently well to seek and give the right type of assistance and to make adequate application of the borrowed technique. It is important for the social worker to evaluate the psychiatric resources at her disposal to determine which fit the needs of a given case. It is likewise essential that a psychiatric clinic evaluate its services in terms of their value to the referring agency. This is the same thing as saying that the most effective treatment of the case can be accomplished only through continuous efforts on the part of the clinic to examine and interpret treatment implications in the work of the social agency handling the case, as well as through that agency's ability to learn from such interpretation how to apply to its case-work the mental-hygiene principles indicated.

The psychiatric social worker is in a position to make contribution in the matter of aiding the psychiatrist to see concretely the social worker's problems and her limitations in handling them. To do this, she must translate such concrete experiences of her own as may be of assistance, and she must as far as possible keep herself informed about the functions and policies of all the fields of social work represented among the referring agencies of her clinic. The working relations of the two social workers are thus kept very close

and misunderstandings are minimized. It is conceivable that any arrangement may then be made and modified as to active contact with the specific case. There are times when the referring agency likes to have the clinic worker take over the treatment of a psychiatric problem and when this can be done to advantage. The supervision of a foster-home placement may be so handled in the case of a difficult child without the children's agency relinquishing its contact on matters of financial arrangements. A family agency may gain ground by supervising only the economic and health problems in a case, while the clinic handles a difficult parent-child situation or an acute marital problem. The psychological factors involved in having the home visited by several social workers are, however, important, and such plans must be carefully worked out by the several agencies concerned.

Working relations that will accelerate rather than block the adjustment process are very important. Experience has demonstrated the pitfalls that are likely to be encountered when two or more professional workers have direct contact with the individual or family under certain emotionally difficult circumstances. It is so easy for one to lose sight of the objectives of the others and so to neutralize values. The elements of this situation have been well recognized outside of the psychiatric field. I have heard a family agency discuss an unsuccessful long-time case and reach the conclusion that although the health and economic problems and the employment and school situations were equally pressing, the family itself could not possibly grasp the essentials of any part of the total adjustment while workers from all of these various fields were actively on the scene. The family agency in this case emphasized an existing logical health contact, interpreted its objectives to the health agency, and stepped off the scene. In cases referred to the psychiatric clinic, the emotional elements are more quickly uncovered, and it should be possible to determine very early through which existing contacts treatment must be directed in order to insure the best results. Conferences between agencies can do much to further treatment on this basis and to bring about the exchange of valuable information.

A case of this kind in which error occurred unnecessarily

was that of a sixteen-year-old girl who had been in childhood so indulged by her father that she had resented growing up to responsibility and to the deprivations that resulted from financial reverses. Her resentment of these things took the form of antagonism to the mother, because responsibility required that she suddenly compete with her mother on the adult level for the approval of her father. At school she presented no problem. This indicated that her difficulties had not carried over into the school and that the good adjustment here must be sustained and capitalized. Shortly after the girl's disturbing behavior, the mother died and the father, not well adjusted himself, accused her of being instrumental in causing the death through her behavior. After that he remarried, on the ground that she could not keep a "fit house". This made an almost impossible basis for the important adjustment between the girl and her stepmother. The stepmother's failure to handle the situation spelled total failure of her marriage and led to unsatisfying marital relations. Coming to the clinic at this point, the case was treated in an attempt to give the girl and stepmother insight and at the same time adult satisfaction in their separate accomplishments. Insight by degree and commensurate with success would presumably be acceptable, less painful, and therefore successfully integrated.

Study revealed the fact that the father had fewer possibilities for reconstructing the situation than the stepmother, although the necessity remained for showing him the destructive effects of pressure on the girl. This indicated that a well-planned treatment attack must be directed toward helping the stepmother to see that the key to the solution of the problem actually lay in her hands. Her recent entrance into the picture made her problem acute, but less involved. She would need to be shown that because she was least responsible for the situation, she might affect it most constructively. About this time a new development affected the plan. The stepmother had a baby on whom she turned a great deal of her attention. The girl, who was very ambitious about schooling, had an opportunity to live with her aunt and continue school when the family moved outside the city. In the aunt's home she showed great improvement. The step-

mother naturally had difficulty at this point in accepting the improvement in which she had no part and began to find fault with the relationship between the girl and her aunt.

About this time, too, the family agency entered the picture, to work out financial difficulties and the father's health problems. The stepmother and the family social worker were very responsive to each other, and the social worker agreed with the stepmother in feeling that the girl's placement with the aunt was weaning her further from the family. She therefore had the girl returned to the home. The two agencies had not worked together closely enough on the fundamental emotional relationships in this family as revealed by the clinic study to permit the family social worker fully to appreciate the clinic's ultimate objectives. Both social workers desired the same results, but differed in their approach to the various problems involved. The family worker in this instance had not been given sufficient interpretation of the emotional factors to prevent her identifying herself too closely with the immediate situation. It was natural that she did not see that the return of the girl at this time was antagonizing her and so doubling the stepmother's problems by renewing pressure on the old area. It was a matter of judging which of two emotional problems should be handled first. Less complete identification with the stepmother might have allowed the social worker to see the more dynamic treatment possibilities in a plan for helping the stepmother to accept the existing simplified situation in terms of her own needs. As it was, her excellent contact with the key individual operated quite unwittingly to destroy the work of the first social worker. Needless to say, interpretation of the case led to a satisfactory joint plan. The girl, having returned to her home, precipitated greater difficulty than ever, so that the family themselves requested her removal. The plan formulated, therefore, was that the clinic social worker should continue to work with the girl and the family social worker with the family. Meanwhile the two social workers coördinated their work by means of constant conferences, and a successful adjustment was reached for family and girl individually, with approximation of the point at which they could adjust to each other.

A comprehensive early conference on this case would have considered ways and means of protecting treatment issues on so difficult a situation. If the two organizations had not agreed on treatment approach, they would presumably have conceded that the active family contact of either one would be more conducive to good treatment than would a splitting of the attachment and dependence relationship so important to success.

Similar difficulty has of course been demonstrated many times when the psychiatric social worker from a clinic has entered a situation in which a family or children's agency social worker was active. It would suggest that where a social worker with a good contact is already active on the case, the adjustment should if possible be made through her. Coöperative work should do everything possible to strengthen her contact. It is not enough to consider that the psychiatric worker may make more rapid headway in a particular situation. If she is unable to sustain her contacts over a sufficiently long period, or if she is not equipped to handle the economic, health, or other aspects of the case, it becomes a serious question whether her efforts and insight should not be confined to working through the referring social worker. The principle has been recognized in the past largely in terms of avoiding duplication of work or trespassing on the specialty of another field. The aspect here touched on, however, is in terms of emotional values inherent in the situation. The patient or client does not easily invest his confidence and enter upon the difficult task of relinquishing old prejudices and facing the hard realities involved in emotional situations. To do this under the guidance of two workers is fraught with increased difficulty. This has been recognized to the point of turning over certain cases within a clinic for all direct work to the psychiatrist, the psychiatric social worker, or the psychologist, as the problem and the contact might indicate.

Personality-adjustment problems, by their very nature, precipitate the question of interpretation and of a meeting ground for the psychiatric clinic and the social worker who refers cases. Furthermore, no clinical analysis is utilized that is not in some measure carried over into the realm of

treatment. Since, as we have already mentioned, the psychiatric clinic cannot substitute for or work without the important social factors that operate in the intellectual and emotional experience of the individual, there is constant need for the social worker who refers cases to assimilate the mental-hygiene values in a clinical study if that study is to be a working tool in her hands. A large proportion of the referring agency's case load involves just such fundamental problems as those referred to the clinic. It seems essential, therefore, that the cases referred should serve as experience for the social worker, educating her in principles that she may carry over and put into use in her future work. As far as possible, then, it would seem advisable for the referring agency to be depended upon to carry out the work of the psychiatric clinic in the home, and for the clinic to plan, interpret, and review in the light of the findings the treatment through the social worker. This is being done in a number of places with success enough to warrant improvement in the technique of conducting staff meetings, treatment conferences, and interviews in which the social worker participates.

There is an increasing demand from the social worker who refers cases for workable interpretative material from psychiatric clinics. Social psychiatry, having been introduced into training courses, is producing groups of social workers who are questioning in terms of emotional problems and who are willing to adopt a new technique in the handling of these. Referring agencies are absorbing psychiatric social workers into their staffs. We are liable to a certain amount of irritation as a result of this rapid growth in the appreciation of psychiatric values from the two directions—the psychiatric clinic and the referring agency. Without sufficient preparation for the job of handling the situation, we risk the irritation resulting, on the one hand, from the demand of the psychiatric clinic for more adequate histories and treatment facilities on cases referred for study and, on the other hand, from the demand of well-informed referring agencies for better clinical services. In the forward-looking group, each welcomes the problem as an opportunity for more mature work.

Study of the nature of the problems referred by the social

worker who carries her own case into the clinic and back again into her own field is absorbingly interesting. The able-bodied father who has failed to support his family and has responded spasmodically or not at all to the social worker's planning and replanning with him may with great difficulty be persuaded to see a psychiatrist. The social worker is sensitive to the resistance of the man, who knows that he has failed to "make good" according to the standards of his struggling wife and relatives and the outside agencies that have had to attempt rehabilitation. Her experience leads her to hope for new light from the personality study which may help her to make a new approach and to ascertain the limitations inherent in the man. Her experience, however, does not give her much conviction as to the immediate satisfaction the man will obtain from the examination. Thus her sense of a risk involved in persuading him is at times her liability. Sometimes, on the other hand, she expects an immediate solution and later suffers a lost contact with the man who was promised too much.

The average social worker prepares a history to meet the requirements of the clinic under considerable pressure, being called upon to reorganize the material in her perhaps voluminous record and to construct personality pictures that have for the most part been considered only in her verbal conferences with supervisors. To put them in writing as criteria for a psychiatric clinic arouses mental reservations and a consciousness of contradictory findings difficult for her to evaluate. It is not strange that she sometimes fails to find any expression for the material on which she is so anxious to get assistance or that she sometimes protects herself from her own harassing questions by preparing a definite and convenient, but less true, picture of personalities. Especially if she has regarded the clinic as a last resort, the young worker has great difficulty in sustaining as tentative the steps in her case-work as she reviews it at this time. In the face of a big case load and the emergencies inherent in, for instance, the case of a mother and baby for whom a shelter must be found within eight hours or the child who must be placed in a foster home within a few hours, the writing of a good history for the psychiatric clinic is a real task.

It removes pressure when the social worker and the clinic realize that the history involves a difference in emphasis rather than content. It is little wonder that for the most part only those cases that indicate commitment or other special care that may relieve the social worker of a discouraging job are carried to the psychiatric clinic or that only at the point of exhaustion does the early adjustment problem reach the clinic.

Under these conditions, it is quite usual for the social worker to omit from her history a statement of the problem that does justice to herself or to her organization. Too often she states the problem in terms which she probably feels are necessary to its admission for clinic study. In a sense, she feels called upon to submit her diagnosis of the personality problem. The clinics have perhaps unwittingly brought this about. It may be quite unrepresentative of the steps in her thinking, the experience she has already met with, or the real need she now has for psychiatric interpretation. The result too frequently is that the clinic, on the basis of this history, passes back to the social worker verdicts and recommendations that sound to her trite and very like an echo.

When, however, the social worker is able to portray what measures were actually tried and under what conditions, and also just what she is up against at this point, she forces the clinic to interpret her experience and add to her insight into the problems involved. Many of the clinics, in the present stage of development, would be at a loss to give her what she really needs. This kind of interpretation implies a much more profound piece of work on the part of the clinic. It means either a thorough study of the case at a great expenditure of professional services on the part of the staff or, without the data derived from such a study, the difficult task of so integrating the various factors in the case and the plan for treatment as to permit the social worker to proceed to the best advantage.

If the report of the clinic does not show an appreciation of the functional limitations of the social worker's agency, much worth-while mental-hygiene material may be discarded as not workable. On the other hand, the average clinic is not in a position fully to grasp the administrative and work-

ing problems of the many referring agencies. The social worker can aid tremendously by indicating her problems if the clinic will actually make use of them. A glance at the social worker's case load entire reveals a mass of family personality situations fraught with obscure emotional problems for the social worker's handling. If some of these are to be handled adequately through the application of psychiatric principles, the expenditure of time that will be necessary for dynamic results must apparently be faced by both fields.

The actual reading of the social worker's own record by the clinic staff, in addition to the social worker's interpretation, would afford greater possibilities of interpreting the case. This would mean further evaluation of the case's experiences with the agency, and a guaging of the treatment potentialities in the situation at this point. Psychiatric interpretation of record material without examination of the client is being worked out by a number of social agencies on their own staffs. Where this is developed and the insight from it diffused throughout the case-working group, one can feel the increased appreciation of emotional factors throughout the work. When cases, then, come to a psychiatric clinic, there is indeed need of dynamic psychiatric interpretation beyond the diagnostic stage.

The coöperative service carried on by psychiatric clinics in many cities has led to modifications to meet particular staff needs. It has usually been conceded that a more adequate service could be effected by a few of the most mature social workers in an agency that refers cases frequently to the clinic. However, the practical situation generally makes it seem advisable for as many of the agency's staff as possible to carry at least one case through the clinic. This obviously minimizes the opportunity for building a social worker's mental-hygiene point of view upon successive experiences with different types of cases. Also, it does not carry her beyond the arduous task of the first psychiatric history—to a point where she is more conscious of content than form. On the other hand, it serves as a general orientation on working with the clinic. The social worker may have one or many conferences with the clinic supervisor before and during study and treatment of the case. The clinic supervisor's ability to anti-

cipate the social worker's difficulties and to give her ammunition in keeping with her background largely determines the value of the coöperative work. The preliminary discussion of a case referred often results in the rejection of the case as one on which the clinic can make a less valuable contribution than on some other case being handled by the worker. It is important that the social worker put her time on a case in which she can feel the value of the treatment rather than on one that may give her a sense of futility; and the clinic can guide her in this.

In Cleveland, Philadelphia, and other cities, various types of service have been worked out between the child-guidance clinics and case-working agencies in the community, in addition to the regular coöperative handling of cases with continuing service through periodic treatment conferences with the clinic staff. The agencies have felt that there is considerable value in the consultation service, which may consist of a discussion, by a psychiatrist and a social worker from the clinic, of the case as presented by the worker on the case. In this way the mental-hygiene aspect of the case may throw light on the agency's treatment plan, may suggest new steps, modify old plans, and change the point of emphasis. A larger number of difficult situations can be ironed out by this method in cases that might not warrant complete clinic study. It seems to meet one of the agency's needs in handling a large case load. Discussion of the principles involved is more important and more feasible than specific recommendations on this cursory basis.

As another means of carrying over mental-hygiene principles for the use of an outside agency, several of the best equipped workers in the agency have been assigned to a child-guidance clinic, for periods varying from three to six months. These social workers carry a cross section of clinic cases under supervision and participate in all clinic activity with the objective of later making application of the principles involved in their own particular fields. Some of these social workers, upon return to their organizations, have continued in their former rôles. Some have been given more specialized jobs, such as sorting cases for reference to the clinic through discussion with their own staff.

The close contact between the clinic and the supervisory staff of an agency insures the most effective coöperative work. With this in view, a group of secretaries and supervisors have sometimes asked for discussion with the clinic on their problems.

There has been in general little discussion of or attempt to work out the common ground of general case-work and social psychiatry. Both fields place the highest value upon the family relationships as basic in the environmental experiences that shape the social adjustment of the individual. They are two approaches to the same thing. It might be said that social work mobilizes the data necessary for understanding and adjusting family problems by evaluating each individual's accomplishments in the light of family-rehabilitation standards and the resources at hand. It might be said that dynamic psychiatry mobilizes the individual more particularly in terms of his emotional equipment for adjusting to the resources at hand. Obviously each field has a contribution to make to the other.

There are unexploited avenues of understanding in the two fields that might be worked out in a further exchange of concrete services. The clinic's own case load could frequently profit greatly by advisory service from the social agency that has developed special services, such as the home-economics department. Without the benefit of such service on the clinic's comparatively small number of problems of this kind, it is very difficult for the clinic to keep up to date on the important by-products of, for instance, the work of a relief-giving organization. It is so easy to lose sight of the value of mobilizing natural resources in the economic situation of a family by directing matters of insurance policy, citizenship as a basis for mother's pension, and so forth, of which the family are unaware. The guidance of a family in the use of these resources requires familiarity on the part of the social worker.

In the fusion of the fields, new phraseology, so irritating at times, may be of great assistance. If new phraseology carries important new concepts, it is important for the interpretation of one field to the other because it can stimulate fresh, vivid thinking. Yet a great many terms are used even

within the psychiatric field with varying shades of meaning. It is helpful to recognize this when, for instance, the clinic discusses with the social worker who refers a case the insecurity felt by a child whose parents made him feel very early certain limitations or certain unloved qualities and yet who is self-assertive. The child's self-assertiveness is certain to belie the diagnosis if further explanation is not made of his particular personality patterns and reactions. A plan based on this point may be discarded if there is not a mutual understanding of the underlying concept that the child at an early age cannot but accept the statements of the all-wise parent, no matter what injustice he may sense, and that emotional experiences at this helpless age may leave a scar, regardless of subsequent opportunities for success.

Psychiatric interpretation, when it is most constructively made, can give the social worker a sense of relief rather than that of a very difficult job to be done. Presentation of the suggestions as prospective tools in her hands adds to her sense of adequacy. Indication of the points in her own material that have interested the psychiatrist in her further findings stimulates her intellectual curiosity. Psychiatric values become her values as she sees that she has already laid the ground work for them and realizes something of their practical value to herself. Considerable unexpected ammunition may be given her, for instance, by interpreting the mental-hygiene values of certain contacts she evidently sustained in her relationship with the client. Her appreciation of a client's feelings, apart from her insight into the facts in the client's situation, if pointed out for its treatment value, can give her a basis on which to build a real understanding of emotional problems. The clinic often overlooks the mental-hygiene values in the work already done and so loses an opportunity to evaluate for the social worker an important part of her technique. Yet this is apt to serve as her greatest asset when it comes to grasping new values or correcting erroneous approaches.

She may, for example, welcome the suggestion that there are constructive possibilities for both parents and children in focusing the attention of Mr. and Mrs. B. upon praiseworthy qualities in their children. If she has been harassed

up to this point by her failure to impress the B.'s with a sense of responsibility that will stop their drinking for the sake of their children, she needs to see a new approach as one that lifts pressure from herself. A whole new field of possibilities may open up when she finds that these direct efforts to get the B.'s to see their responsibility have only driven them deeper into the discouragement that poor health and irregular employment brought about. Responsibility not met was making the children loom up for the parents as further barriers to success, and the children were suffering repressive methods of discipline from really affectionate, generous parents. Stimulation of their pride in the children and sense of feeling respectable enough to enjoy them might serve as a new approach if the psychology of it could be clearly shown. The social worker might find real ammunition in this and might greatly conserve her own energies. A clinic recommendation that the B.'s needed "more outlets and a greater sense of satisfaction to assist them in their efforts to stop drinking, and that the children were suffering from the effects of maladjustment and pressure in the home" might only have laid an additional burden upon the social worker without further interpretation. The social worker, after all, has her own need for outlet after a long experience of failure to adjust an alcoholic case that is imperiling the entire family group. If only indirect treatment can be expected to accomplish any results, she must be shown specifically why, in order to justify in her own mind the patience and time required to do the same thing with her ten apparently similar cases. If her standard of success on these cases, with similar symptoms, but varying causes, is placed too high or aimed at one level, she may set herself an impossible task.

Similarly, if she does not know from a psychiatric clinic or other source why a particular marital situation is not within her power, or that of any one else, to alter, she will naturally continue to locate the fault for herself and perhaps break down, by the very process, the thin structure that should be maintained as representative of the best adjustment the two individuals in question can be expected to make. But the social worker cannot be expected arbitrarily to give up her standards of rehabilitation.

Adequate explanation of the situations in which the social worker is justified in being a "good mother" to the client in whom she is trying to foster independence and sense of adequacy is one of the guides that the psychiatric clinic can give. The several necessary steps toward the goal appear contradictory if not adequately discussed. Clues that will help her to see for herself the treatment value in plans that will constructively preserve the client's ego have real value for the worker. Success in the manipulation of these factors is essential to her continued utilization of this understanding of human behavior. It is, therefore, important that the clinic present such values in as dynamic a way as possible and under the conditions in which they are most pertinent.

Frequent criticism of psychiatric recommendations comes from the fact that they appear too lenient toward some one individual. The constant emphasis is on relieving pressure on the individual. It is true that psychiatry has been guilty of too much individualization and too little cognizance of involved family groupings as permanent factors in the situation to be treated relatively. It is, however, more often true that the clinic, under the limitations of a formalized report or under pressure for time, gives only the high lights of its analysis and recommendations and fails to see that the social worker must plan in terms of the next step and the chessboard situation in the family as well as of the ultimate goal to be accomplished. Much of the seeming over-emphasis is the result of the clinic's effort to interpret the patient vividly if he is an immature individual whose need is to grow up to his adult responsibilities step by step in accordance with his emotional readiness for it. Here the clinic may not be in position to say how far this process of guiding the individual may have to be determined by future developments in the whole family picture. That may have to be largely the job of the social worker. In fact, in brief types of service the clinic frequently has to outline the needs of the individual examined and to make suggestions for meeting them, frankly leaving the application of the principles to the organization that is actively carrying on treatment. In the last analysis the clinic can go only so far without making recommendations that are the functional responsibility of the original agency. Formaliza-

tion of such lines of responsibility would be destructive to progress in this whole field of coöperative work. It frequently happens that desirable mental-hygiene needs cannot be met by another agency without conflicts of various types. When this situation is made the common problem of the two fields, greater understanding of treatment is evolved.

There are in process a number of interesting experiments in working relations that are suggestive of ways and means of meeting this problem of the needs of social workers who refer cases to the psychiatric clinic. The indications are that development along these lines will further the whole treatment technique, through constant interpretation to each of the other's field.

PSYCHIC FACTORS IN JUVENILE DELINQUENCY *

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RICHARD CABOT is quoted as saying: "How diverse the virtues—how similar the crimes! Is it not amazing—the smooth uniformity of nail biting, bunking out, truancy, obscenity, and theft? In these elements, the stories are so much alike that one almost forgets which is which until the child himself speaks up." [1]

This is a clear preamble to the subject matter of this paper. The behavior of people is strikingly uniform, in both its normal and its abnormal manifestations. They have a very limited number of ways in which to behave. The delinquent acts of juveniles show this striking uniformity, and yet how diverse are the personalities and the backgrounds and the individual life experiences that are back of this behavior and that determine its direction! The recognition that each personality is a new emergent and that behavior, uniform as it may appear to casual observation, is the resultant of individual life adaptations, has determined the trend in recent years of social and medical sciences dealing with behavior. The keynote of this trend has been the endeavor to know more about the individual and to obtain a better understanding and evaluation of the variety of life experiences and situations that contribute to the development of the personality and shape the manner in which it behaves.

Prior to the influence of this more dynamic approach, social work was largely an alleviative process aimed at immediate situations. Psychology was concerned with detached samples of activity and academic considerations of will, reason, instincts, emotions, and so forth. Psychiatry was a formal study of symptoms which were classified and standardized

* Read at the Sixth All-Philadelphia Conference of Social Work, February 9-12, 1927.

[1] Quoted by R. G. Gordon in *Personality*. New York: Harcourt, Brace, and Company, 1926. p. 261.

into rigid disease entities. And criminology in theory was concerned largely with statistics showing the influence of climate, race, economic conditions, heredity, and a host of other factors upon the development of crime, and in practice with the determination of the guilt or innocence of a specific act and its punishment if guilt was established. The extent to which these sciences have become humanized is in direct proportion to the amount and application of the interest that has been developed in the dynamics of individual behavior as opposed to an interest that was concerned only with the behavior itself.

Other sciences have progressed only by applying the experimental attitude. The physicist would have known very little about the properties of water if he had studied only the behavior of hydrogen and oxygen. The psychiatrist would know very little about a human being if he studied only an isolated sample of his activity detached from its setting. We see an individual who is very domineering, another who is very suspicious, another who breaks into a store, another who has a temper tantrum, and another who is afraid of cats. These samples of activity are not isolated phenomena. They must be related to very definite factors in the life of the individual. Behavior being purposive, each of these activities is serving some definite purpose for the individual in question. The study and determination of these factors, the evaluation of the purposes that are being served, and the possibilities of redirecting the activity into other channels form the central interests in a dynamic psychology which centers its attention on the individual.

This point of view applies to all forms of behavior. There is no reason why we should have a dynamic psychiatry for the understanding and treatment of the behavior we observe in dementia-praecox cases and then close the doors for its application to the understanding of the behavior we observe in a juvenile delinquent or a child who is having violent temper tantrums. In each instance we are dealing with surface indicators of processes going on in a human being, representing the interplay of a variety of factors, some hereditary, some physical, and some arising out of the variety of life experiences and human relationships in the individual development.

The understanding of these factors gives us a better working knowledge of the individual and of the behavior that represents his method of adapting himself to this situation as it stands.

Fundamentally, therefore, there should be no difference in our attempts to understand the dynamics of the various types of behavior. The psychiatry that is applicable to one type should be applicable to other forms. The difficulty lies in the emotional barriers that hinder the development of an objective attitude in regard to certain types of behavior. The community may have very little difficulty in accepting the more dynamic and objective approach to those whose behavior indicates that they are mentally sick, but it will be much less certain about the application of the same principles to those individuals whose behavior stamps them as delinquent. We probably think of these problems too much in terms of sickness and health, and thus block the effort to study the dynamic factors back of the behavior of those who are not sick in the ordinary sense of the term.

The establishment of the more elastic type of procedure found in a few of our juvenile courts, the stimulus of Healy's work, which stressed the necessity of individualizing study and treatment, and the development of child-guidance clinics in community, school, and court, primarily designed to broaden our knowledge of individual behavior and to develop a technique of treatment, are helping to open the way to the use of more scientific methods in handling and treating other forms of behavior abnormalities than those found in the mentally sick. This is particularly marked in the case of the juvenile delinquent.

The application of this more individualized type of approach is changing the emphasis that has been placed on certain facts. Reasons for atypical behavior frequently have taken the form of mass explanations and rather dogmatic generalizations. In the more formal days of psychiatry, this could be seen in the reliance placed on heredity or morbid constitutional make-up as an explanation for mental disease—or in the insistent demand for an observable type of pathology of the central nervous system as a common factor in the various forms of abnormal behavior. Somewhat the same

philosophy has dominated criminological studies. Even though we have passed beyond the dogmatism of the Lombrosian school, with its insistence on fixed criminal types and its view of their behavior as the predetermined expression of their abnormality, we still hear of born criminals and moral imbeciles. This tendency to explain behavior by rather fixed generalizations left little room for a more individual approach. The sterility of this whole point of view probably encouraged and hastened the development of more dynamic interests.

Mass generalizations are still very much in vogue, but under the influence of an individual type of psychology, they are given a somewhat new meaning. For example, most studies in delinquency emphasize mass environmental factors. Every study gives the various races represented, the percentage of foreign born, the number that come from broken homes, the economic conditions of the families, and so on down the conventional list. This is all very valuable information, but there has been too great a temptation to stop here and feel that explanations have been obtained. There has been a tendency to forget that these facts represent merely handicaps to individual adjustments. In each of these situations there is always an individual attempting to work out a plan of living. The special relation between environmental strains and the individual's adaptation to them has to be determined. The combination of hydrogen and oxygen does not always make water. A nagging mother and a broken home do not always create a thief. Under certain circumstances, however, such results are produced. The variability of the human factor makes it impossible to duplicate the experiment with others, as is possible in physics. This is what makes it so necessary to study the individual as he strives to adapt himself to the setting in which he is developing, if the experiment of nature is to be understood.

In this short paper, it will be possible to discuss only certain aspects of some of these strivings and see how they are related to the commission of a delinquent act. The particular striving that I want to discuss is that which concerns the individual's struggle to attain self-respect, self-confidence, and an adequate sense of his own individuality, and the types

of behavior that are related to it. The drive to attain this goal motivates a great deal of both normal and abnormal behavior. The failure to attain it by means of socially constructive types of activity may lead to any one of the various manifestations of abnormality, among them being various types of delinquency. One cannot study the detailed histories of individuals without being impressed with the dynamic significance of this struggle and the compensatory efforts that they make to overcome any feelings that cause them to seem different and inadequate and inferior.

This struggle, which is common to all, arises because we must live and grow with other human beings. This involves competitions and comparisons. Estimates of our successes and failures are evaluated largely in terms of other people. We feel inferior or superior in these terms. This criterion is particularly potent in childhood and adolescence. We see samples of this in the young child who glories in the fact that he is bigger than his next-door neighbor, or who is humiliated because he has to wear clothing that is out of style. The successful establishment of the individual in the group by means of socially acceptable forms of behavior is fundamentally important. If attained in the early years, a foundation for sound mental health is laid down. Failure to attain this self-respect and self-confidence usually leads to the development of unhealthy compensatory activity which, if not corrected, may form the basis for a criminal career or for one of the various nervous and mental disorders.

This process is related to delinquency in that delinquency is one of the common forms of compensatory effort made by individuals to overcome some of their handicaps. In analyzing the histories of sixty stealing cases studied in the child-guidance clinic, it was found that in nearly half of them the stealing and associated activity were related definitely to feelings of inadequacy which had their roots in various factors in the life situation of the child. Common among these factors were physical characteristics which stamped the individual as being different, such as obesity, speech defects, undersize; mental defects of varying degrees; certain habits, such as enuresis and masturbation; racial prejudices; presence of more attractive and gifted brothers and sisters; im-

morality and desertion of parents; economic factors; failure to achieve a healthy emancipation from parents; and repressive discipline. Each of these factors occurs more than once in this small series of cases.

These were some of the factors that brought about a sense of being different, inferior to others in the group. They placed barriers in the road to healthy attainment of self-respect and self-confidence. The delinquent activity was part of the compensatory effort of the individual to overcome these handicaps. The operation of these factors is illustrated by the following three cases:

The first case was a boy of fourteen who embezzled a considerable sum of money from his employer and was using the money for making a big splurge at a local amusement park. Previous to this serious offense, he had stolen small amounts at home. The main sources of the difficulty in this case were:

1. A very oversolicitous mother who insisted on treating this boy as an infant. Before company he was always introduced as "my baby". She supervised all the details of his clothing and dressing, she gave him spending money only as he needed it, and in many other ways prevented him from growing up.
2. The father, a large, masculine type, was very stern and rather repressive in his handling of the boy, and somewhat inclined to scorn his lack of virility and his rather infantile type of personality. This discrepancy in the attitudes of his parents was having a very destructive effect upon the self-respect of the boy.

His decision to leave school at fourteen to go to work was a significant gesture of the boy to test himself. He felt very insecure about himself, particularly in relation to the somewhat older adolescents whom he met in his work and at school. The desire to establish himself was a very keen one, but his background had given him very little confidence in his ability to do this in a normal way. The stern and awe-inspiring discipline of the father, combined with the coddling of the mother, did not make a very firm foundation upon which the boy could stand when placed on his own. The quick-

est way to gain his goal and to compensate for his obvious immaturity was to get money. He proceeded to do this and to make the impression that he felt was necessary if he was to become a "regular fellow". It was also an opportunity to prove to himself that he could do something unsupervised by his mother.

The second was a fifteen-year-old boy who had been stealing, playing truant, and associating with a very undesirable gang. The chief sources for the very definite feelings of inadequacy that were present in this boy were as follows:

1. He was mentally inferior and had great difficulty in completing fifth-grade work and in competing with the younger children with whom he was associated.
2. He was physically inferior, especially in contrast to a very robust brother who bullied him and controlled his behavior while he was at home.

In the home, where he was faced with the wide discrepancy between himself and his brother, he was a cringing, fearful, stuttering boy. He sought companions of his own level and with them he soon established a reputation for having a lot of nerve. When he was with them, he did not cringe, nor did he stammer. He was an individual here, admired for his nerve and for his daring in carrying out burglaries and thefts. About his stealing activities he said, "I don't want to steal, but something in me makes me do it. And if I don't steal, the gang would think I was a sissy. It would mean I didn't have any nerve." The thing that was in him that made him steal was his craving for recognition which he was unable to get in any other way. The fear of the gang's scorn was greater than the fear of a long prison term. In view of these facts, there is little wonder that strenuous attempts on the part of the family to separate him from this crowd failed. They moved miles away from that neighborhood, but back he went. The threats and punishments of the brother increased his fearfulness at home, but made it only more certain that he would get back to his crowd, which offered him his only source of satisfaction and gave him assurance that at least he was a good thief.

The third case is that of a rather sober, but active, in-

telligent boy of thirteen who was found guilty of stealing things at school and at home on several occasions, and was suspected of it on many others. The basis of the original stealing episode is not clear, but the following factors seem related to its continuation and to the very marked feelings of personal insecurity present in the boy:

1. His own mother died when he was eight. Among the very few episodes that he recalled in connection with his mother, he related one in which she accused him falsely of taking something. It apparently made a deep impression. After the mother's death, a very domineering and disagreeable aunt took charge of the household. He resented her constant interference and her tendency to compare him with her own children, who were models of conduct. She distrusted him and was always trying to fasten guilt upon him for one thing or another. Some of the stealing that went on in the home gave him a certain sense of power over his aunt.

2. The other factor concerned the school situation. He was caught stealing something for his wheel and tried to defend himself by lying. His reputation was established as one who could not be trusted and it passed from one grade to the next. He was suspected when things were missing and while he was guilty in some instances, frequently he was innocent. He was isolated from other children, partly through their attitude, partly from his own sensitiveness and feeling of being an outcast. Some of the later stealing was based on the reasoning that as long as he was blamed for this, he might just as well go ahead and do some of it. The sense of isolation and insecurity was evidenced by his increasing soberness, his loss of interest in everything, and his feeling that no one trusted him, and never had—not even his mother when he was a small child.

I have used these three cases to illustrate the dynamic importance of factors in the life of a child that interfere with the attainment of the necessary self-respect and self-confidence, and to show how a delinquent act may emerge as a compromise form of activity which partially satisfies some

of these strivings. The cases illustrate also the different point of view that eventuates if we avoid explaining behavior merely by generalizations and seek a knowledge of each individual case. The usual type of generalization in the second case would have been that the delinquencies were the result of bad companions. If treatment had been directed toward the elimination of that factor, the real source of the difficulties would have remained untouched. Such a procedure would be analagous to treating a syphilitic ulcer with a cautery and leaving the blood-stream infection untouched.

The real value of the individual approach to the delinquent is in treatment. A plan of action can be made that is directed against the sources of the difficulty rather than toward its surface manifestations. The treatment plan in those cases that are based on the psychic mechanism just described must be directed toward one or more of three things:

1. The elimination of one or more of the sources that are feeding a sense of inadequacy. As many of these factors are fixed, it is necessary to resort to another approach.
2. Changing the attitude of the individual and others in his environment toward the source of the difficulty—a procedure that usually involves the third step, namely:
3. Redirecting the activity into more socially constructive channels, strengthening the constructive assets of the individual, broadening interests, and creating opportunities for new ones.

A fourth and somewhat negative line of approach is the avoidance, as far as possible, of creating new sources of difficulty by mistaken methods of handling those already developed. The public humiliation of a child in home, school, or court would be a rather common example of how this could be brought about.

Let us return for a moment to a discussion of some of the treatment considerations of the three illustrative cases. A., the first boy, the one who was crippled by the parental methods, had to have a chance to free himself from the dependent relationship that had been fastened to him and to gain a healthy degree of confidence in himself. To bring about this

result and change the methods and attitudes of the parents so that it might be achieved seemed almost impossible while they were all together. A plan was finally worked out between the parents and the boy which enabled him to go away to a boys' school for a period of a year and a half. This removed him from the chief source of his difficulties, yet gave him sufficient supervision and expert guidance to enable him to work out a healthy sense of his own individuality which we hope will carry over when he returns to his own home.

It is obvious that the second boy presented very few constructive possibilities in the situation in which he was placed. Probably it involved placing him in an institution where he could be given a training that might enable him to compete by means of a more socially acceptable type of behavior. The case is an important illustration of the fact that even mental defectives have strivings toward the attainment of a certain amount of self-security and recognition, and a great deal of the delinquent activity of this group can be traced to the fact that they are trying to "put themselves over" and to gain a satisfying compensation for their obvious inferiorities which they cannot gain from competitive activities with their more normal associates.

The third boy presented a rather difficult problem. There was not only delinquent behavior, but also a rather serious warping of the personality. The first task was to change the attitude of the boy toward himself and also the attitude of others toward him. The first could not be accomplished directly because he had no confidence in any one. The second was possible because teachers and parent were willing to start a new program. He was promoted to a grade in keeping with his mental ability. The attitude of the teacher was changed to one of trust, made manifest by simple things in the classroom. The attitude of the other pupils changed when they saw that he was being trusted. And in the home, the father took a more active part in his life, and the aunt moved on. The effect of these changes were seen gradually in the changed behavior of the boy. His interest in school returned in response to the confidence placed in him by the principal. He thawed out under the same approach on the part of the teachers, gradually lost the bitter and somber at-

titude that previously had marked his entire behavior, and his stealing stopped. The treatment process has extended over a considerable period, and the boy's confidence in himself has been built up to a fairly stable level.

In each of these cases the delinquent activity was satisfying a very real need. True, it was a destructive form of satisfaction, but nevertheless it was real. Dependence upon correctional and punitive measures for its elimination would have accomplished very little because the real sources of the difficulty would have remained.

It is essential to realize this in the case of the great majority of juvenile offenders that are found in every community. Something besides mere punishment and correction is necessary. The measures that are necessary in each case can be determined only after an understanding of the dynamic factors have been reached and a plan evolved that will strike at the roots of the problem. When more of this is possible in our courts—and primarily in our juvenile courts—the community will be doing more and more real preventive work. It will cost more money to do this because it will require a better trained and a better paid personnel, but what could be more expensive than many of our present methods? A large proportion of adult crime grows out of our failure to handle successfully and constructively the juvenile offender. Healy has shown recently that over 60 per cent of a large group of juvenile cases handled by present correctional methods went on to a later criminal career, and concludes that a great many of these would have turned out differently "if they had been understood and their individual needs met".[1] To do this means the wider application of a more individual type of approach which seeks an understanding knowledge of the psychic factors at work in each case, an approach that is necessary not only in our juvenile courts, but in the classroom, the home, and all other community organizations that deal with the child.

[1] *Delinquents and Criminals: Their Making and Unmaking*, by William Healy, M.D., and Augusta F. Bronner. New York: The Macmillan Company, 1925.

THE UNMARRIED MOTHER; A SOCIO-PSYCHIATRIC VIEWPOINT *

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IN approaching the study of this subject of illegitimacy, it is highly desirable to find out what kind of people make up this group of unmarried mothers. And immediately one is in difficulty. In searching through the recent literature one is struck by the number of conflicting statements concerning these women who are the subject of our inquiry.

However, five factors at once clearly present themselves. In the first place, these unmarried mothers are mostly young; over 75 per cent are under twenty-one years of age. Secondly, most of these mothers come from the economically inferior strata of the population, the majority of those gainfully employed being domestic servants or semi-skilled factory workers. In the third place, to a large extent they are of inferior mentality. On this point, as might well be expected, there is the greatest divergence in the available statistics. Percentages varying from 7 to 98 may be found in the literature. In the fourth place, over half of them have previously been delinquent, a third of them previously immoral. Lastly, well over half of these mothers come from homes in which there are immorality and alcoholism, poverty and dependency, absence of parental training and guidance, yes, even in some instances encouragement of wrongdoing.

However, we cannot blindly continue to accept these bromidic common-sense interpretations of the situation. Our aim should be the discovery of the motive that lies behind the act. Granted for the moment that the unmarried mother is a young moron who has been employed in domestic service; that as a child she had inadequate home training, due to the ignorance, poverty, and alcoholism of her parents. Must she of necessity

* Luncheon address, Inter-City Conference on Illegitimacy, Des Moines, May 17, 1927.

fall into sex, or any other, delinquency? There is no evidence to substantiate any such opinion. Our job, then, is to learn what it is that leads this girl to indulge in illicit sex relationships and what she seeks in choosing this method of expression. Furthermore, the evidence, from such statistics as we now have, shows plainly that there is no justification in assuming that of necessity there exists a casual relationship between sex delinquency and mental pathology. The data we now have come in great part from clinics and institutions. These cases do not constitute a fair sampling of the cases of illegitimacy. Hence we must be careful not to assume, though there be high correlation, that there exists a casual relationship between illegitimacy and mental defect and disease. Then, too, there is evidence accumulated from the psychiatric and mental-hygiene fields which shows plainly that many behavior disorders constitute essentially normal adaptations to life situations.

It is unwise to generalize in regard to any behavior or conduct problem and probably least wise in the field of sex. Moreover, just to sweep aside all inquiry into this realm of sex and sex activity as a behavior problem is to close the door on any satisfactory comprehension and intelligent treatment of the problem of illegitimacy. Approaching the problem in a scientific way, one at once seeks for causes within the individual herself. Now, no one holds that external factors do not play a part, and indeed a big part, in bringing about personality and emotional reactions on the part of the girl. No human being lives in a vacuum, and hence the environment, both static and dynamic, does much in making her what she is. Excluding rape, her response to any given sex situation is, in its last analysis, her own. Whether she see reason for modifying her behavior, or is even actually aware of her ability or inability, if left to her own resources, to modify her conduct, is quite another matter.

That there are certain pathological states in which the sex urge for expression is unduly and disproportionately strong is no longer denied. Of this we have physiological proof, in that we know that certain internal glandular secretions do bring about precocious sex development, and indirectly, as an

accompaniment, an increased urge for sex expression. Such a girl is quite naturally, therefore, excessively equipped sexually. But to say just that and no more is of little aid in solving her problem. For the girl need not, because of her constitutional make-up, give way to her sex desires. Other factors are operative. One frequently overlooked is the discrepancy between the precocious sex development and the development of normal inhibitions which depend on the age of the girl and the training in morals and socialization that she has received. The precocious sex development may be far ahead of the girl's mental development and here, as elsewhere, we must not forget that few children make serious efforts to maintain moral ideals against the insidiousness of their temptations. We see, then, that a purely physiological explanation for such a girl's sex misconduct is entirely too simple. Nor need we suppose that, had we a physiological cure for precocious sex development, that alone would bring about a change in such a girl's conduct.

It may occur, and it in fact does, that though a girl has no more than the normal sex drive, yet she may lack ordinary normal inhibitions. Here, then, we have a pathological basis for her misconduct, just as in the precociously sex-developed girl. In this latter case, moreover, we would expect to find a definite causal relationship between her weak inhibitions and her intellectual level. And chiefly because of this causal relationship we do find a high correlation between mental defect and illegitimacy. But it is well worth while repeating that a high correlation does not of necessity imply a cause-and-effect relationship.

The feebleminded class is composed of individuals of various levels of intelligence and inhibition. The idiots and low-grade imbeciles are not much more interested in sex matters than children of corresponding mental age. These, if they transgress in the sphere of illicit sex relationships, are most often the innocent victims of degenerate males, their trangressions brought about the more easily because of the low moral standard of, and inadequate supervision in, their homes. Fortunately, the solution of this phase of our problem is relatively simple. It demands early institutional care of

these low-grade defectives *if* home supervision is not highly satisfactory. However, in dealing with the higher grades of mental defectives the problem is much more difficult of solution. Possessed of weak inhibitions, yet, all too frequently for their own good, of attractive physical appearance, these girls become the easy prey of unscrupulous men—and that the more easily since the normal channels of ego satisfaction are in great part closed to them. They, as is normal to all human beings, crave attention and affection. In order to gain the first and frequently under the guileful expression of the second, they submit to sex relationship without a thought of its probable consequences or any intention of accepting its probable responsibilities. Forsaken by their erstwhile friends, but now under the influence of the driving power of their sex impulses, hardly if at all checked by their normally weak inhibitions, many of them drift into promiscuity, when sooner or later pregnancy ensues, to end either in abortion or in the birth of an illegitimate child. Complicate the problem still more by assuming that such individuals come from homes of poor moral standards and of inadequate supervision and it is no wonder that this group has come in for the greatest share of discussion in this problem of illegitimacy.

But in addition to those who are suffering from pathological conditions that contribute to the delinquency, there are individuals who are quite normal physiologically and intellectually, but who engage in illicit sex relationships as an expression of a definite behavior tendency. Frequently such an individual uses her sex life to overcome or to compensate for thwartings of desires or of activities in other directions, or to gain consideration and through it expression of other desires and interests. On another occasion at this Conference of Social Work[1] I have told the story of Carmella, a fifteen-year-old illegitimate girl of normal physical and intellectual development. At the age of ten she submitted to the advances of an immoral stepfather, hoping thereby to gain kindlier treatment at his hands. Foiled in this, in fact cruelly treated by him, she yet continued to submit up to the time of his

[1] *Psychiatry as an Aid in Social Work.* Read at a Round Table Conference of the Girls' Protective Council at Des Moines, May 14, 1927.

desertion of the family. Upon his desertion she very soon became promiscuous. To this stepfather she has an unhealthy attachment, as is indicated in their corresponding with each other. May we not then look upon her promiscuity as an unconscious protest?

Then there is the girl who has come to feel herself unfairly treated by parents and siblings. She is the "ugly duckling", let us say. In her endeavor to find social outlets and to compensate for her feelings of social inferiority, she may overstep the bounds of propriety, thereby gaining the attention and affection she now so keenly misses, compensating for her feeling of unfair treatment, and finally enhancing her own ego in its struggle for social esteem. Healy in his writings has repeatedly called attention to the relationship that exists between sex misconduct and mental conflicts.

However, one must not overlook that type of girl who deliberately and consciously chooses to gratify her passions. Here the behavior is not due to unconscious, repressed complexes. There is no mental conflict in this case. Such a girl's conduct depends solely upon her acceptance of a low ideal. In intelligence she may be quite normal or even superior, but because of her acceptance of a low ideal, there is no adequate stimulus of the will, and her actions are left to the mercy of her impulses; and illegitimate motherhood is but accidental to illicit sex relations.

The last groups to which attention must be called in any review of this subject are the psychotic and the more serious psychoneurotic disturbances. Here the individual definitely fails in her attempt at adjustment along socially acceptable lines. Often sex promiscuity in such individuals is but an expression of the breakdown of the normal inhibitions or a freeing of former repressions due to the mental ailment.

These, then, are some of the fundamental underlying causes of illegitimacy. In approaching, therefore, any solution of the problem of the unmarried mother, we must lay sentiment aside and take an objective attitude toward the problem. Search must be made for the basis of her maladjustment. Such search must include not only a study of the social and environmental situations, but above all else a thorough, painstaking investi-

gation of her personality. This, I fear, has in many instances not been the method of approach. It may account, also, for the seemingly constant seeking for a panacea which many apparently hope to find in the legal field. The problem fundamentally is a socio-psychiatric one. This is not to be interpreted as meaning that no legal aid is considered necessary. We do need better laws and a more enlightened view on the part of judges concerning the feebleminded and the psychotic. The legal profession must come to accept competent medical diagnosis of mental pathology and the recommendations of competent social agencies, so as to accord the defective delinquent and the mentally ill girl opportunity for proper care and treatment either in an institution or under careful supervision in the community.

Then, too, we need such modification of existing laws that all legal proceedings may be heard in chancery. The reasons for this are quite simple. The state then would become guardian for the delinquent mother and the child, so frequently dependent. Then instead of the state being the prosecutor, it becomes the defendant of the unmarried mother and her child and thus the protector of their interests, as well as its own interest in them. As a result, too, the question of guilt becomes secondary to the matter of reasons for behavior.

Moreover, chancery procedure permits the judge to utilize *social evidence,* since the object is not to determine guilt and inflict punishment, for which legal proof would be necessary, but to determine as far as is possible every factor that entered into the production of the delinquency, so that the case may be managed in the best interests of all concerned.

In chancery procedure, too, there is privacy as well as informality. The case is a matter for the judge and his official family, not for the public gossip-mongers. Hence none but interested parties appear and no publicity is given to the case.

Further than this I do not believe we ought to go in demanding more legislation; in particular because our inadequate handling of these cases is not ascribable in most instances to too little law, but is due to our present state of knowledge about this whole subject. I would call to your attention the

fact that most of the hue and cry for more laws comes from those primarily interested in the care of the illegitimate child.

It is through the study of the personality of the girl that we gain insight into the reasons back of her misconduct. These reasons she herself must come to see and thus she must come to accept herself as she really is. Only by admitting to herself the thoughts and desires back of the impulses and drives can she gain control over them. Instead, then, of telling her to put sex out of her mind, she should be helped to accept sex as a part of herself and to give it psychological expression. During the war, and even after, it was customary to tell the so-called shell-shocked soldier to try and forget all about the war. Did he do it? Evidently not, for none recovered when so treated. Instead he was induced to accept the fact that he was afraid, the very thing that caused him to lose control of himself. For he who accepted his fear as a quite normal reaction did not become shell-shocked. The unmarried mother should, then, be made conscious of her reasons for reacting as she does and the possibility of controlling her sex urges should be pointed out to her. Just here is where the real task of social work comes in this field. It is not enough that the girl gain insight as to her motives, but her sex life must be associated with healthy emotions and the emotions liberated must be redirected to new ends. All this is frequently an Herculean task because of the girl's own resistances and the social and environmental obstacles that have to be overcome.

Often, long before the mother is prepared for it, legal battles are undertaken in an attempt to prove paternity, in order to obtain support. The result very often is a relapse on the part of the mother into an embittered and antagonistic state of mind. She develops a grudge attitude toward worker and society at large. All too frequently she is dismissed or lost from observation while still in this mood, as a result of which she preys upon society in an attempt to gain satisfaction and very often revenge for real or imagined wrongs.

There is, moreover, in the very pregnancy itself, a factor not sufficiently utilized, but on the other hand often deliberately destroyed. I refer to the mother's maternal instinct. For its full utilization mother and child should not be sepa-

rated, at least not during the trying time of the mother's readjustment to herself and to society. Cognizance of this might well be taken by those who are so ready to separate mother and child. In assuming responsibility for her child the mother not only has work to do, but she has a normal outlet for her pent-up love. Mother love, moreover, is an outlet for her former sex hunger and that outlet a socially most acceptable one.

In concluding, let me urge a more careful study of all illegitimacy cases. And if my concept of this problem be right—namely, that it is primarily a socio-psychiatric one—then such a study can best be carried out by social worker, psychologist, and psychiatrist, workers trained to appreciate the value of emotional and personality factors in the behavior of an individual and skilled in the treatment of such disturbing behavior. To this end every city should pool its resources and make an organized effort to determine by careful studies the causative factors in illegitimacy, which will throw light on methods of prevention, as well as methods of treatment, that will lead the unmarried mother to make satisfactory social adjustments either in the community or within institutional walls.

THE INTELLIGENCE AND SOCIAL BACKGROUND OF THE UNMARRIED MOTHER

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THE Research Bureau of the State Board of Control of Minnesota last year conducted a psychological study of a group of unmarried mothers. In order to be reasonably sure that the mother had regained her health after the child was born, we waited until the baby was four weeks old before giving the mental examination. It was, therefore, necessary to select our cases exclusively from the maternity hospitals which keep the girls for the three months' nursing period. There are seven such hospitals in the Twin Cities, and all our material was necessarily drawn from these.

When we planned the study, our aim was to examine every unmarried mother who stopped at these hospitals whose child was born during the period from December 1, 1924, to November 30, 1925. When we began to work, however, we found that this was impossible, as a great many of the girls left the hospitals for one reason or another before their time was up. There were 415 cases reported to us as entering the hospitals, and out of this number 71 were unavailable for the examination, for the following reasons:

1. Suffering from contagious diseases	9
2. Baby died and mother was allowed to go home as soon as her health permitted	10
3. Given special permission to leave before time was up	33
4. Refused to take examination	2
5. Examined when pregnant	9
6. Got married and left as soon as health permitted	7
7. Died at childbirth	1
	71

As these reasons were varied, we felt that the 344 remaining cases were still an unselected group and sufficient in number for our problem.

All but eight of the cases were examined by the writer, and these eight cases were examined by members of the research bureau, viz., Dr. F. Kuhlmann, director; Miss M. E. Burmeister and Miss Margaret Lima, mental examiners.

The method used was the following. As soon as four or five of the girls at any one hospital became eligible for the examination—that is to say, when the baby of each had reached the age of four weeks or over—a mental examiner went out to the hospital and gave them the group test that has been devised and used in this department for many years.

If the result of this test established an I.Q. above 80, this result was used, but if it came to 80 or below, an individual test [1] was given and the result of this was substituted for the group-test result. One hundred and eleven girls, or almost one-third of the entire group, were given the individual test.

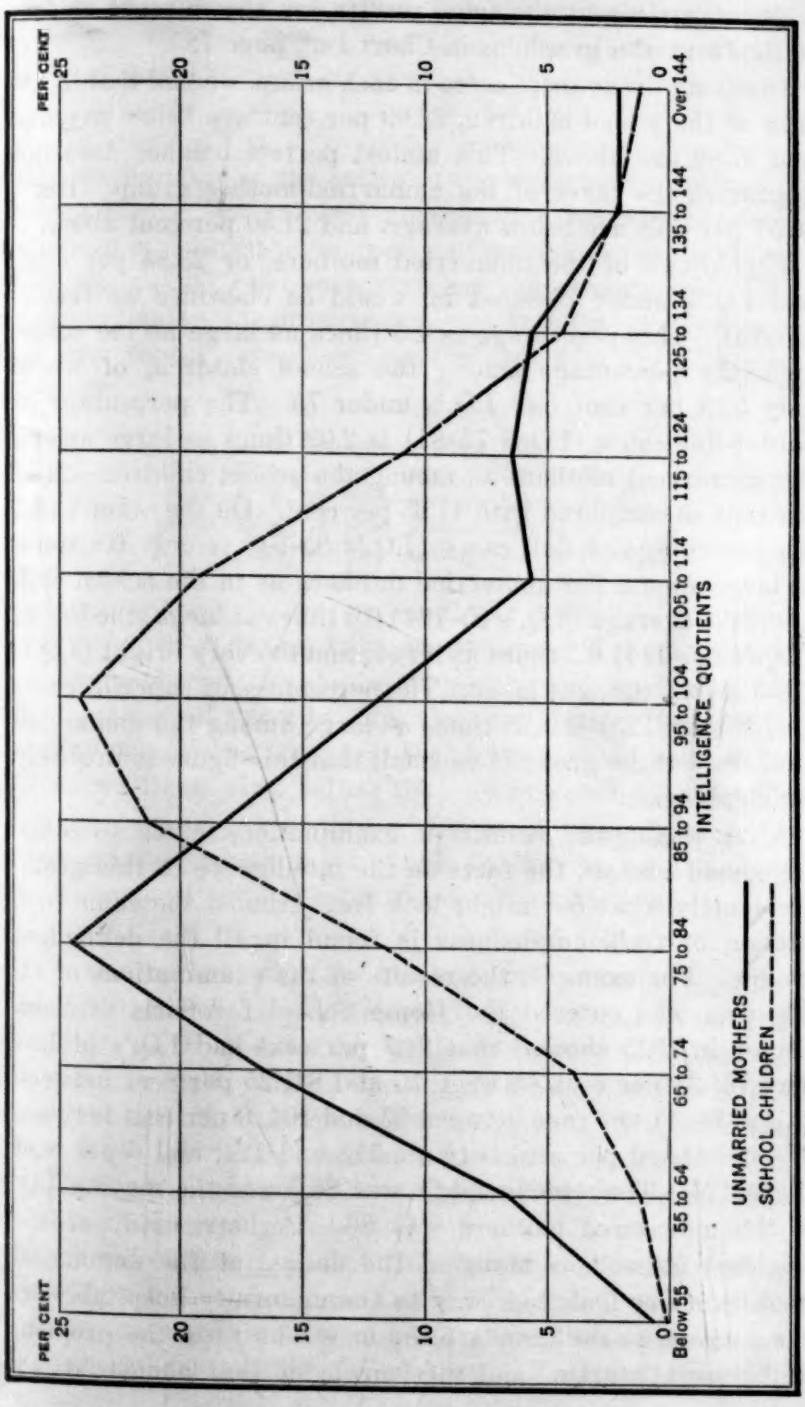
PSYCHOLOGICAL RESULTS

The results obtained from the mental examinations are given in the following table in connection with the results of examinations of 7,656 unselected school children in eleven towns scattered over the state. The examinations of the school children were made also by the research bureau and were conducted in the same way as those in the present study.

INTELLIGENCE QUOTIENTS OF 344 UNMARRIED MOTHERS COMPARED WITH THOSE OF 7,656 SCHOOL CHILDREN.

I.Q.	*Unmarried mothers*		*School children*	
	Number	Per cent	Number	Per cent
Below 55	3	0.87	12	0.16
55–64	22	6.40	78	1.02
65–74	57	16.57	306	4.00
75–84	84	24.42	892	11.65
85–94	63	18.31	1,628	21.26
95–104	41	11.92	1,840	24.03
105–114	19	5.52	1,476	19.28
115–124	22	6.40	838	10.95
125–134	19	5.52	335	4.38
135–144	7	2.03	159	2.08
Over–144	7	2.03	92	1.20
	344	100.00	7,656	100.00

[1] See *A Handbook of Mental Tests*, by F. Kuhlmann. Baltimore: Warwick and York, 1922.



INTELLIGENCE QUOTIENTS OF 344 UNMARRIED MOTHERS COMPARED WITH THOSE OF 7,656 SCHOOL CHILDREN.

A comparison of the same results are shown more clearly in the form of a graph, as in Chart I on page 785.

Omitting the average cases in each group, we find that in the case of the school children, 38.09 per cent are below average and 37.89 are above. This almost perfect balance does not appear in the curve of the unmarried-mother group. Here, 66.57 per cent are below average, and 21.50 per cent above.

Eighty-two of the unmarried mothers, or 23.84 per cent, had I.Q.'s under 75—that is, would be classified as feeble-minded. This percentage is 4.6 times as large as the corresponding percentage among the school children, of whom only 5.18 per cent had I.Q.'s under 75. The percentage of border-line cases (I.Q.'s 75–84) is 2.09 times as large among the unmarried mothers as among the school children—24.42 per cent as compared with 11.65 per cent. On the other hand, the percentage of dull cases (I.Q.'s 85–94) is only 0.8 times as large among the unmarried mothers as in the school children; the average (I.Q.'s 95–104) 0.5 times as large; the bright (I.Q.'s 105–114) 0.3 times as large; and the very bright (I.Q.'s 115–124) 0.6 times as large. The percentage of superior cases (I.Q.'s over 125) is 1.25 times as large among the unmarried mothers, but the group is so small that this figure is probably not significant.

After seeing the results of examinations given to other delinquent groups, the facts on the intelligence of this group are exactly what one might look for. Almost the same proportion of feeblemindedness is found in all the delinquent groups. For example, the results of the examinations of all the girls who entered the Home School for Girls at Sauk Center in 1925 showed that 24.7 per cent had I.Q.'s of less than 75, 21 per cent between 75 and 84, 25 per cent between 85 and 94, 11 per cent between 95 and 104, 6 per cent between 105 and 114, 6 per cent between 115 and 124, and 6 per cent above 124. Their median I.Q. was 85.5 and the median I.Q. of the unmarried mothers was 86. Perhaps many of the brightest as well as many of the dullest of the unmarried mothers never find their way to the maternity hospitals, but those whom we do know are the ones who form the problem of the social worker, and the knowledge that almost 50 per

cent, or one out of every two, are either feebleminded or border-line cases will give her some idea of what she can expect of them.

AGE

The median age of the entire group was twenty years, and the age having the greatest number of cases was eighteen. Seventeen and seven-tenths per cent were less than eighteen years old, and 55.2 per cent were less than twenty-one years. Relating this to the intelligence, we find that the younger they are, the brighter they are, as shown in the following summary:

From 15 to 19 years	average I.Q. is 92.0
From 20 to 24 years	average I.Q. is 90.5
From 25 to 29 years	average I.Q. is 85.2
From 30 to 34 years	average I.Q. is 74.0
35 years and over	average I.Q. is 63.6

Interpreting these figures, we made the deduction that many of the brighter girls are delinquent because of the impulsiveness or emotional instability of youth, and need only the sobering effect of years to solve their problems. If this is so, does it not seem that the ideal social work would be to get in touch with these girls before they become delinquent? The facts seem to show also that so far as learning from age is concerned, the feebleminded remain forever young and therefore in constant need of supervision and protection.

SOCIOLOGICAL RESULTS

In addition to the psychological data, we have collected some facts on the social side. These facts were obtained from the histories on file in the Children's Bureau, which is also a department of the state board of control. The following items, with their subdivisions, were the ones decided upon for our report: amusements, occupation, school record, home life, life after leaving home.

Upon examination of the histories, it was found that no one item was recorded for all of the 344 cases. On the contrary, some of the subdivisions of these items appeared in the histories comparatively seldom. While the results of

these probably do not throw much light on the subject, we give them for what they are worth.

Amusements.—As the amusements of the girls were not recorded in the histories as such, but only incidentally and almost entirely in connection with their delinquencies, we have, comparatively, only a small number to report. They classify as follows:

Public dances—named 52 times or in 48 per cent of the recorded cases.
Auto riding—named 23 times or in 21 per cent of the recorded cases.
Parties and entertainments—named 15 times or in 14 per cent of the recorded cases.
Movies—named 12 times or in 11 per cent of the recorded cases.
Outdoor sports and games—named 6 times or in 5.5 per cent of the recorded cases.

Although this is far from being a complete report of the recreations of our cases, it probably is indicative, to some extent at least, of the way most of them spend their leisure time. Evidently, going to public dances is their most common form of amusement and outdoor sports the least common. Whether this indicates that the public dance is more apt to be a cause of this special form of delinquency than other amusements cannot be judged by these figures as we have no way of knowing what the results on this topic would show in an unselected group of girls. Our guess is, however, that in this day and age dancing would be found to be the most indulged-in recreation.

Occupation.—We were successful in getting a report of the occupations of the girls in 288 of the cases.[1] In order to simplify the subject, we have classified these on the basis of the training required. In the first, or A class, we have put the occupations that require a high-school standing plus some special training. The occupations falling in the A class are rural or small-town school-teacher, trained nurse, bookkeeper, stenographer, professional tailor. In the B class are the occupations that require, in most instances at least, a high-school education. The occupations in this class are the dentist's or doctor's assistant, filing clerk, office girl, radio-

[1] No report was given on this point for 12 of the cases and 44 never had been employed outside the home.

laboratory assistant. In the C class are the occupations that need experience as a necessary qualification. Here we have beauty-culture assistant, sewing woman, practical nurse, ward nurse, dry-cleaner, hair dresser. In the D class we have mechanical labor with practically no supervision: saleswoman in modest capacity, errand girl, utility girl, stamp girl, bundle wrapper, press feeder, mail sorter, housekeeper in modest home. In the E class, we have mechanical work with supervision: factory work, laundry work, dish-washer, waitress, plain cook, chambermaid, hotel work. Although these classifications are somewhat rough, the median I.Q. for each class seems to indicate that they are fairly well graded. Following is a summary of the results:

	Number of cases	*Median I.Q.*	*Per cent of cases*
Class A	23	124	8.0
Class B	8	96.5	2.8
Class C	8	90.5	2.8
Class D	46	93.5	16.0
Class E	203	81	70.5
Total	288		

Seventy and five-tenths per cent of all the cases in the E class is undoubtedly an exceedingly high per cent for an average group, but is exactly what one might expect from this group for the following reasons: first, in any occupational group, average or otherwise, most people are doing work below their intellectual level, especially young people; second, 48.26 per cent of our group have I.Q.'s below 85; and third, 55.2 per cent are less than twenty-one years old. These three factors are no doubt the reason why such a large percentage are in the E class.

The average length of time that these girls hold their positions is 9.8 months, which probably indicates that they are unstable as a group in addition to the fact that so many of them are incompetents.

School record.—The school record was given for 322 of our cases. It was found that 59.3 per cent had never reached high school. The figures from the state department of educa-

tion show that 48 per cent of all the school children of Minnesota never reach high school. This means that the percentage of unmarried mothers is more than one-fifth too large, which can be accounted for by the excess in their number of subnormals.

Home life.—Our next step was to see if a contributing cause could be found in the home life of the girls. In this connection the histories revealed the following facts:

9	—no record of home life
219	—homes had both parents
16	—homes had stepmother
12	—homes had stepfather
24	—homes had no mother (dead)
31	—homes had no father (dead)
1	—home had no father (insane)
2	—homes had no mother (insane)
7	—homes had foster parents
7	—homes had no parents
14	—homes had no father (separated)
1	—home had no mother (separated)
1	—girl was reared in an orphanage
344	

This gives us 23 per cent of our girls coming from the broken home, considered so only if it was broken before the girl was eighteen years old; 8.1 per cent having a step-parent; and 2 per cent coming from foster homes. With no figures at present that show the percentage of similar conditions in homes among girls in the general population, it is difficult to say how much or how little these conditions contributed to the delinquency of these girls.

Occupation of fathers.—The number of fathers in the home, including stepfathers and foster fathers, amounted to 281. Of this number, no record of occupation was found for 16. Our report, therefore, is based upon 265 cases. Fifty-eight and five-tenths per cent of these men were farmers. For convenience, this group will be designated as class A. Computing from the figures given in the United States Census of 1920, we find that 50 per cent of the whole population of Minnesota is rural. We would, therefore, expect to find 50 per cent of our

unmarried mothers to be country girls. But actually we find 58.5 per cent, which is over a sixth more than we expected. The other occupations of the fathers were classified in four groups. Class B consists of professional men: dentists, ministers, and so forth. Class C are highly skilled, such as the merchant, cashier of bank, painter and decorator, and so forth. Class D consists of the semi-skilled worker, such as the car repairer, shoe repairer, packer in wholesale company, and so forth. Class E are unskilled laborers of all kinds. The following table shows the results of this classification:

	Number of cases	*Per cent*
Class A	155	58.5
Class B	5	1.9
Class C	27	10.2
Class D	32	12.1
Class E	46	17.4
Total	265	100.0

Size of family.—The average size of the family, recorded in all but 13 of the cases, is 6.2. This becomes significant when we compare it with the average size of the family in Minnesota. In *Birth Statistics,* published by the Department of Commerce of the United States in 1919, the average size of the family in Minnesota is given as 3.5. In a study made by our department of 337 families having one or more members feebleminded, the average size was found to be 7.17. This figure comes so much closer to our 6.2 that the conclusion seems obvious that excess in the mental deficiency of this group is a contributing cause to the size of the family. In its turn, the size of the family is probably itself a minor cause of delinquency. More than half of these girls—55 per cent—came from families of six or more children, 44.5 per cent of seven or more, 32 per cent of eight or more. Nineteen of the families had ten children, eight had eleven, nine had twelve, four had thirteen, one had fifteen, and one had seventeen. In the poor or very moderate homes that most of these girls come from, the large family means crowded quarters, lack of privacy, less delicacy of feeling, and lack of almost all the material comforts. It means that the older ones must get out and shift for themselves before they are prepared to

care for themselves properly, or must at least find their recreation outside of the house. It means that there is no time or place for the personal interest and talks that children should have from and with the parents. In one of the histories an observer was quoted as saying of the family: "The children are turned out like cattle." Three and four-tenths per cent were "only children". Although we were unable to find any statistics with which to compare this, on the face of it it seems a small enough percentage to refute the theory that only children are so spoiled when they are young that they are more apt than other children to become delinquent when they are older.

Other conditions of home life.—An attempt was made to find some one item in the recorded descriptions of the homes that held constant in a sufficient number of cases to make it significant. But no such item was found. Twenty-four of the homes were reported as being poor and neglected. Seventeen had very strict fathers. Thirteen were said to be immoral—that is, with an "immoral tone" or with one or more other members immoral. In nine of the homes the children were reported to have practically no supervision. The smallness of these numbers is probably due to the fact that in most instances the history has been given by the girl herself and not many are willing to tell of the detriments of the home life. Perhaps they do not recognize these conditions as detriments, and see nothing unusual to report.

Life after leaving home.—The question has often been raised as to how many of these girls get pregnant while still living at home. The following summary shows our findings on this topic, having been computed from 330 of the cases:

Pregnant before leaving home:
(a) in the country—16.6 per cent
(b) in the small town—20.0 per cent } 54.8 per cent
(c) in the city—18.2 per cent

Pregnant after leaving home in country and going to small town—13.0 per cent.

Pregnant after leaving home and going to city—1st year, 3.6 per cent; 2nd year, 6.1 per cent; after 2 years, 22.4 per cent.

It is rather surprising to find that more than half of these

girls became pregnant before they left home. Evidently, agencies outside the home should not wait until the girl is living elsewhere before giving her their moral support. And judging from the small number who became delinquent the first and second years after they came to the city, the social worker might save a great many from this false step if she could find a means of directing their activities during the first two years of city life.

The burden to the state.—In 1924 there were 1,065 illegitimate births reported in Minnesota. About 50 per cent of all illegitimate children reported are supported by the state for at least four years. According to these facts, there are about 500 of these children added each year. This makes a constant number of about 2,000 who are being supported continually by the state. Computing from the five-dollar-a-week-board basis, which is a very rough computation, the state is paying half a million dollars every year for the support of these illegitimate children. And this does not tell half the tale. In the first place, a great many births are not reported to the state, but later these children become dependents. Secondly, a large number of those who are dependent the first four years of their lives are not adoptive and remain charges all their lives in one institution or another. Even many of those who are adopted appear later in the various state institutions. It seems that it would be more economical for the state, first, to support more club houses and neighborhood houses where girls would be housed better, entertained better, and supervised better; second, to employ more social workers and visiting teachers; and third, to spend more money for the detection and care of the feebleminded.

RECOMMENDATIONS

First, that every unmarried mother be given a mental test as the first step in the effort to understand her as an individual.

Second, that the ones found to be feebleminded be prevented, if possible, either by segregation, close supervision, or sterilization, from having any more children.

Third, that more ways and means be provided for reaching young girls before they have become delinquent.

Fourth, that the county superintendents, the social workers, and the churches of the small towns and country districts watch out for their girls leaving school to see what they do and where they go.

Fifth, that the churches, social workers, and teachers do not overlook the girls who are living at home, as they are just as apt to become delinquent as the girls who have left home.

SPEECH DEFECTS IN CHILDREN

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THE study of speech defects in school children is a subject that has been receiving pronounced attention from educators and the general public in the last few years. Because speech defects are often symptoms of emotional, mental, or organic disturbances, the subject is an interesting one, holding the same element of popular appeal as the abnormalities studied in psychoanalysis. Unfortunately, however, lecturers and educators are too often led by the impressiveness of the subject into a multiplicity of theories, opinions, and generalizations which, though extremely interesting, are not always of a scientific nature.

There can be no question that the matter of speech defects in school children is a subject worthy of study. As an educational problem, it merits all the time and effort that can be placed upon it. But would it not be wise to direct this time and effort along more systematic and scholarly lines? In view of some of the lectures and publications of the last few years, it is surely not an undue criticism to state that fewer generalities and more earnest study and research are needed before speech defects can be accurately defined, recognized, and treated in our public schools.

There are certain things that we know regarding speech defects, but there are other things that we just as surely do not know. We know a few of the causes of speech disorders. We blame a great deal on the home and the parents, and perhaps our blame is rightly placed, for we see mothers who strive to keep their children "their own sweet babies" for as long as possible by encouraging baby talk and lisping. We see children who have speech defects only because they are imitating their parents who have the same defects. We see home conditions that promote timidity, jealousy, shyness, a lack of self-confidence, or an extreme nervous tension, all of which may lead to speech difficulties. And we see speech dis-

orders arising from a psychic trauma or a nervous shock received in the home.

Environment alone, however, cannot be postulated as the sole cause of speech defects, or even, possibly, as the most important cause. There are the physical disorders and the poor health conditions which may be wholly responsible. And there are the nervous and mental disorders which are the cause of a large percentage of speech defects. These disorders may or may not be connected with some definite physical disease.

That any one of these three factors may cause speech defects we know, but to discover a cause is sometimes a long way from solving a problem. We may say, "Poverty is the cause of crime", but that does not get us very far. Poverty is not always the cause of crime, and when it is, the mere statement of the fact does not remedy the crime situation.

Speech defects are not a simple problem. They are often tremendously complex and bound up in the personality of the individual. Fortunately, they are not found in any considerable percentage of our population. The minor speech blemishes of poor articulation, enunciation, and the like are common enough, but the major defects are found in only a little more than 1 per cent of the public-school enrollment, if the figures from our larger school systems are correct.

There are many types of speech defect. The public naturally thinks of stammering, but stammering is only one of the several major disorders. The various types of defect are often interwoven, but how interwoven we do not know. One often leads to another, but how we can only surmise. Are there some defects that should not be treated at all lest overemphasis increase the defect? Does a cure of a nervous and mental disease always affect a speech disorder that has been caused by it? What are the physical ailments that most often cause speech disorders? Are children with speech defects on the average normal in general intelligence?

With regard to the last question—intelligence—we hear contradictory opinions. One professor of speech hygiene informs his hearers that "the stammerer generally possesses superior intelligence, so that his thoughts outrun his speech". Another lecturer, a normal-school instructor, has stated that

"children with speech defects are usually dull mentally. They have to be trained to correct defects that the brighter children never contract."

Binet testing of children with speech defects in the St. Paul public schools indicates that neither of these statements is true. If the amount of testing done is sufficient to give any general conclusions, children with speech defects seem to be neither brighter nor duller, on an average, than other children. They are, in fact, quite within the normal range. A résumé of one study may be given here.

Speech-correction classes in the St. Paul public schools run an average enrollment of from 375 to 400 pupils. Over an entire year, however, more than this number are handled because cases are dropped from the speech classes as soon as they show sufficient improvement. In this past year, 402 children with speech defects were given individual intelligence tests—Binet (Kuhlmann revision). The median I.Q. of this group was 97.7—just average.

The children tested were being treated for the following defects:

1. Stuttering and stammering
2. Lisping
3. Letter substitutions, omissions and additions (including so-called "baby talk")
4. Oral inactivity (indistinct speech, when the front of the tongue is dormant, or the jaws and lips too passive)
5. Delayed speech
6. Pronounced nasality
7. Unusual accent (foreign accent that does not yield to regular-grade treatment, and so forth)
8. Organic malformations—cleft palate, harelip, or tongue and laryngeal deformities.

It will be seen that these classifications are not all-inclusive. A child's defect may be a combination of any two or more of these, and an exact diagnosis of any one cannot always be made. However, using them as rough classifications whenever possible, we made the following division of the cases:

Defects	*Number of cases*
Stuttering	122
Lisping	113
Letter substitution	103
Oral inactivity	22
Lateral lisp	11
Delayed speech	17
Nasality	4
Unusual accent	6
Organic malformations	4
	402

With regard to the physical abnormalities of children with speech defects, there are many that are noticeable: defective hearing, enlarged glands, malnutrition, defective teeth, diseased tonsils, defective nasal breathing, and the various malformations of the jaw and palate. Children with speech defects are often underweight. In 1922, of all the speech cases enrolled in the St. Paul speech classes, 42 per cent were underweight, 45 per cent of normal weight, and 13 per cent overweight. Strangely enough, lispers seem to form the majority of the underweight children. It often happens that when the physical defect is removed, the speech defect vanishes, but the contrary is just as often true—obvious physical defects may be totally removed, but the speech defect remain. However, we have only too little exact data on this.

Nervous and mental diseases and emotional abnormalities in children with speech defects are the factors concerning which we probably know the least. We know that children with speech defects are often emotionally unstable; they are often nervous, excitable, tense. But we know, too, that this nervous or emotional instability has generally an environmental or physical cause which we, in school work, cannot always correct. We are, moreover, unable to isolate, examine, and treat all the emotional conflicts that are causing the speech defects. We cannot isolate them because we have no adequate measure for diagnosis. Free-association tests for use with school children are unsatisfactory and insufficient, yet we have nothing to take their place. Even the services of a psychiatrist cannot give assured help. Dr. A. A. Brill confesses that out of 69 speech patients discharged by

him as cured over a period of eleven years, only 5 were permanently cured. Only a man reputably grounded in his profession would have dared confessed this. The charlatans claim 100 per cent cures.

It is surprising, however, to note the number of permanent cures that are effected by trained speech teachers in our public schools among younger children whose speech disorders are not yet deeply rooted or chronic. The good speech teacher, by stressing relaxation, self-confidence, and correct vocalization, often overcomes a nervous or emotional disorder without ever realizing what she has been combating. A few case studies taken from St. Paul school records may illustrate this:

Lisper.—Boy, aged 9. Mentality normal. Appearance tall and thin. Vacant expression, mouth usually open. No obvious physical defects. Vision corrected with glasses. Instrument birth; breast fed nine months. Walked at twelve months.

This boy did not begin to talk until he was two years old. He could not speak plainly enough to be understood until he entered school. His speech, which was at first a pronounced baby talk, changed to a conglomeration of letter substitutions, omissions, and additions, combined with a lateral lisp. At the end of his first year in school, his defect was diagnosed as a pronounced lisp only. It was noticed that he was extremely nervous and overactive. He yelled when he talked, and became easily excited, his voice rising higher and higher. He was always twisting and turning about, screwing up his mouth and nose, and biting his finger nails. The fingers were badly blunted at the ends where the nails had been bitten off continually. He was very finicky about food. He was very timid, and had several minor fears, the cause of which could not be traced. He was afraid of swings and any playground apparatus, of storms, animals, and even of certain children.

Heredity and home conditions seemed largely responsible for his condition. The mother lisped, and a brother could not speak clearly until he reached high school. The sister was a neurotic with many ailments and occasional seizures of hysterical paralysis.

At the end of a few months' treatment, this boy's speech began to improve. At the end of two years, he was discharged as cured. There has been no relapse. He is still nervous and timid, but he has conquered his lisp.

Delayed speech.—Girl, aged 6. Bright mentality (I.Q. 112). Attractive appearance, no physical defects. Normal birth; breast fed. Walked at seventeen months.

This child began to talk at two years, but the speech sounds were unintelligible. When she was about four years old, she stopped talking altogether, and made her wants known only by signs. When she entered school, she seemed to have no speech at all; when the teachers could get her to use her voice, the sounds were unintelligible. For two months,

the speech teacher got no response; the child would not even try. Then suddenly she began to work. She improved rapidly, and within a few months she could give every speech sound and could repeat words correctly.

She was an extremely timid child, but she did not seem especially nervous. She was quiet, seemingly relaxed, and interested in the things about her. There were never any signs of fatigue during school hours. At home she was quiet and well-behaved, and chattered often in her queer speech. She slept well and quietly at night, and seemed to have no night terrors. The family history showed an alcoholic father, but the mother was divorced from him and had married a second man who was kind to the child. There were no speech disorders in the family on either side. The only significant fact elicited from the family inquiry was that the real father had occasionally come home drunk, when the child was quite small, and frightened her in some way. Once he shook her until she was unconscious because she had cried. Whether this childhood fright had occasioned the speech defect or not, no one can say, but the supposition is possible, and the diagnosis was therefore made as delayed speech due to psychic trauma received in infancy.

The child's speech is now wholly intelligible, at the end of two year's treatment, and a prognosis of complete cure seems reasonable, especially as the child's fairly stable nervous and emotional endowment would probably forestall relapse.

Letter substitution.—Girl, aged 6. Mentality normal. Defective posture, breathing, and chest expansion. Normal birth. Rickets at one year, followed by convulsions. Health now rather poor. Tonsils and adenoids removed. Walked at twelve months.

This child fidgets constantly, pulls at her dress, smiles nervously without cause, sucks her thumb even in school, and seems unable to sustain attention or to concentrate. She is infantile in her reactions and is self-conscious. Her mouth is usually open, and her head bobs when she talks. She is always happy and busy, and seems to enjoy school, though she is very timid and does not like to play with the other children on the playground. The most noticeable thing about her is her frequent state of nervous exhaustion. She becomes easily fatigued in school, so much so that she is unable to sit up in her seat. She will slump and almost fall. At home she is restless, although always happy and talkative. She sleeps restlessly and has frequent night terrors.

The home conditions are fairly good, but the mother had thought the child's speech "cute" and had conversed in an exaggerated baby talk with her. At the advice of the speech teacher, the child was taken out of school and put on a special diet and rest régime. Now that she has returned to school, she is being given speech-correction work, and her defect seems yielding to treatment.

That it is not always possible to control nervous and emotional disorders, every speech teacher knows. Stutterers seem especially reluctant to yield up their defects. In the two following cases we, in St. Paul, have failed to affect a cure.

Stutterer.—Boy, aged 11. Considerably underweight. Instrument birth; bottle fed. Walked at thirteen months.

This boy did not begin to talk until he was two and a half years of age. His speech was then mumbled and indistinct. When he was three years old, he was run over by an automobile. He remained unconscious, or only partially conscious, for two weeks. The last faculty to come back to him was speech, and then he stuttered badly. When he began school, his stutter was mixed with a lisp and bad letter substitutions. The speech teacher was, in the course of two years, able to clear up the lisp and the substitutions, but the stutter remained, neither improving nor growing worse.

This boy's chief claim to fame is that he shows a decided "dual personality". One day he is happy and good-natured, the next cross and difficult to handle. At first, the teachers merely considered him moody, but it was noticed that in his two different moods, his whole personality changed. When good-natured, he dresses neatly and takes pride in his appearance, carries a pocket comb, and keeps his hair smooth; he laughs easily and seems happy. When in the opposite mood, he insists on wearing overalls all the time, even to school, his hair is unkempt, his appearance untidy, he cries easily and without cause, and his speech defect and school work are bad. He may remain in one mood for weeks, or may change daily. His mother has learned to know by his greeting in the morning with which personality she has to deal that day.

He is always contrary and restless, he goes into tantrums easily, and his anger seems uncontrollable. He is finicky about food and wants to eat nothing but toast and pastry and to drink nothing but coffee. He is timid and cowardly, and is afraid to be out at night. He never plays far from home during the day. Still, he assumes a certain bravado of manner and swears often. He demands constant attention and is overaffectionate. There is a great deal of the abnormal and unpleasant in his demand for physical affection. He is disliked and avoided by all children, especially his own brothers and sisters with whom he never "plays fair".

He has been diagnosed as a manic-depressive type, and the prognosis for the permanent cure of his stutter is poor. It is significant that his speech defect is least noticeable during the summer months, and it grows worse under treatment, probably because he accentuates it then to enjoy more fully the attention he provokes.

Differing in every detail from the above is the following case:

Stutterer.—Girl, aged 15. Bright mentality. Unusually attractive appearance. Health, posture, and gait normal. Normal birth. Walked at one year.

This girl began to talk at about twenty months. Her speech was clear and distinct with no defect, not even baby talk. When she was five, her mother died, and shortly afterward the father noticed that the child was stuttering. When she was seven, her brother died, and her stuttering became noticeably worse. At about this time, her tonsils were removed, and that, too, seemed to aggravate her defect. Now

she stutters whenever she talks about home affairs or school, or about her desire to be a kindergarten teacher. She invariably stutters on the word "kindergarten". The girl is popular with her friends, and has a happy disposition, although she worries a great deal. She worries over her school work, although she receives good marks, but she worries most over her home conditions which, strangely enough, seem ideal, although her father and sister may be a little oversolicitous and overanxious to help her overcome her defect. This girl, too, shows an improvement in speech during the summer months, and lapses very badly when she returns to school. Curiously enough, she never stutters in French, which she is now studying.

This girl is probably oversensitive and overemotional. Speech-correction classes merely aggravate her difficulty. The prognosis for a permanent cure is doubtful.

It may be of interest to state here that the percentage of children with each type of speech defect differs with the age groups. Letter substitution is a defect found mainly in the first and second grades. Of nearly one thousand children treated for speech defects in St. Paul over a period of several years, nearly 75 per cent of the six- and seven-year-olds were diagnosed in this group. The percentage drops steadily until the junior-high-school age, when the defect is rarely found. Stuttering and stammering, on the other hand, are defects acquired, rather than lost, during the school career. Few very young children stutter. The defect does not seem to get well started until the eight-year level, and it increases in number steadily until the high-school age, when it is practically the only defect noted. This may be because other speech defects often turn into chronic stuttering unless the child is properly treated when young. Oral inactivity remains fairly constant at the different age levels, rising only slightly from the first to the fifth grade, and reaching its maximum in numbers at about the twelve-year level.

The intention of this article has been to give the results of the minor studies noted, and to stress the need for more detailed research in this field. The value of speech correction in schools is great, although the various courses in "public speaking", "speech correction", and "oral English" are so intermingled that it is difficult to determine where one leaves off and another begins. Teachers who are qualified to correct speech defects are surely needed, especially in the lower grades where a minor defect that is curable may lead, if left

uncorrected, to a chronic defect. Too large a percentage of cures cannot be expected. The training of speech-correction teachers is a new venture for colleges and normal schools. The course is often too short—sometimes only a summer-school session—and the speech teacher can naturally receive in that time only the barest elements of knowledge as to the organic, emotional, and environmental causes of speech disorders. However, this special-teacher training is receiving more and more attention, and it is to be hoped that this will persuade research workers to delve further into the field and raise standards that will make the diagnosis of speech abnormalties more accurate and their treatment more efficient.

TAKING THE DOGMA OUT OF THE I.Q.

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THE "constancy of the I.Q." has been hailed as a great boon for education, since it enables us to predict a child's future accomplishment from his present status in an intelligence test. The idea has met with some opposition, but the controversy has for the most part subsided, the honors going chiefly to the holders of the doctrine. To the victor belong the spoils, it is said, but in this case there has been a sort of boomerang reaction, which has made the spoils rather unpalatable. That is, the statistical fact, which it may be said the victors have proved, is that on the average the I.Q. has not been found to vary more than 5 points plus or minus from one test to another, when standard conditions of testing are maintained. This has been taken by lay school people—and by many enlightened school people, it is to be observed—to mean that, no matter by whom obtained, no matter what the conditions of testing, no matter even what qualifying statements may be made by the examiner in reporting the examination, an I.Q. may be regarded as a definite and final label, not "on the average", but for each individual considered.

The writer recently said to a school superintendent, in discussing a boy who had just been examined, that while he had now a very low I.Q. and was certainly mentally inefficient at the present time, it was her opinion that much of this was due to his marked feeling of inferiority, and that if the school could stimulate him and encourage him and give him more self-confidence, a later test might reveal a higher I.Q.

"Higher I.Q.?" queried the superintendent in surprise. "I thought that wasn't supposed to change."

The layman, however intelligent he may be, is very apt to take the statistical fact of an average result for the invariable fact of common sense. When common sense says: "It is usually so", it means that it is so about 95 per cent of the

time; and this is the "apperceptive mass" or the common-sense concept to which the "average statistical fact" is commonly assimilated.

At the present time enlightened school superintendents, principals, and teachers are reading psychological and scientific journals as never before, and are getting ideas from research studies, which they inevitably assimilate in accord with their particular background of knowledge. It seems, therefore, as if research workers should issue more frequent cautions as to the common-sense application of their findings. Instead, however, I believe that psychologists themselves have done some propaganda work along this line which they should not be proud to look back on. To be specific, I believe that the present tendency of the schools to encourage persons, after a brief course in testing, to give individual intelligence tests to children who are school problems is on the whole to be deplored. And I believe that the tendency of psychiatric children's clinics to employ "psychometric examiners" of meager training is even worse, since the public expects the clinic to render expert service. My reason for believing this tendency to be bad is not because there is anything abstruse about the technique of administering tests or anything extraordinarily difficult about the scoring that cannot be learned in a short time by an intelligent adult. The reason is, rather, that without a wide background of psychological knowledge, as well as an extended period of supervised practice in testing, it is not possible to interpret a test adequately. If in 50 per cent of the cases the I.Q. will remain constant, then in any given child who is examined, the chances are 1 to 1 that it will *not* be constant. The I.Q. itself, however accurately the test may have been given and scored, is not enough to tell us on which side of the fence this particular case lies. The inexpert examiner has not the knowledge to help us much, and, indeed, it is always emphatically proclaimed by the advocates of "short-horn" testing courses that such an examiner is not expected to interpret. Of what avail, then, to test? If an I.Q. can be taken at its face value, anybody intelligent enough to give a test can interpret it. If it cannot, then it is of little practical use uninterpreted.

The I.Q. reminds me of a certain type of puzzle picture, familiar to children's pages in newspapers a number of years ago, which, when first regarded, appears as an ordinary scene of a house and garden or what not, but contains, hidden in the lines of shrubbery or roof or clouds, the outline of a face or figure. It may require diligent searching and concentrated disregard of the ordinary "meaning" into which the lines of the picture are automatically fused before one can find the concealed figure. But when this is once discovered, it is amazing how it dominates the picture. Look away from the picture to regain your orientation; look back again and the concealed part still stares out at you in bold relief. The rest of the picture pales into a mere blurred background and the meaning of the picture as a whole is lost.

There is some danger that in interpreting the picture of a child's personality we may find that the intelligence quotient assumes something of the character of such a concealed figure. Though it has been a part of the total picture always, we have only recently discovered it, and it has sometimes stood out with the dominance of the concealed figure of the puzzle picture, so that the meaning of the whole has been overlooked. Of course the analogy breaks down if one tries to carry it further, since the hidden figure is entirely extraneous to the interpretation of the picture, while the I.Q. is an intrinsic part of the individual's personality picture.

Dr. Fernald taught us—at least in dealing with the feeble-minded—not to let mental age and I.Q. alone assume undue importance in our estimate of an individual. We all recognize the importance of considering other factors, such as family history, personal development, and social, moral, and economic status, before making a diagnosis. But there is another step necessary, which we have not always recognized. We must know whether the mental age and the I.Q. are valid measures of the native intellectual ability of an individual, since that is what they are conceived to be. This we can tell only by a psychological interpretation of the test. Having found the puzzle part of the picture, we must take it apart again and fit it into the whole.

These are really two issues—the question of diagnosis and

the question of psychological interpretation. Nevertheless, they are often confused. We may illustrate the first point by supposing two adults, each of whom has a mental age of 11 years and, by Terman's standard, an I.Q. of 70.

Suppose that this represents in each case a valid measure of their ability to deal with the tasks of the Stanford-Binet scale. One of these individuals may show so lamentable a lack of success in attending to his affairs that no one would question the diagnosis of feeblemindedness; the other may live his life peaceably in the community without ever being suspected of needing any supervision. Both have the same mental capacity, but their adaptation to society depends on other factors. These two cases represent the first issue, in which aspects other than mental ability determine the diagnosis. This is perhaps rather a legal or sociological question than a psychological one.

The second issue is a strictly psychological one, and psychologists have by no means always made it clear in their interpretation of their findings to the psychological layman. (May it be added, parenthetically, that medical men, school administrators, and teachers are more frequently than not "psychological laymen" in this respect?) A mental age has been taken at its face value and the resultant I.Q. used as a basis of prognosis with far too few precautions. Given a child who does not refuse to answer questions, an examiner who knows the technique, and a certain allowance for the "probable error" of the measurement, and the average teacher, school superintendent, and physician, who have some acquaintance with mental tests, will accept the mental age and I.Q. without further question. The second point—the necessity of interpretation of the I.Q. itself—may be illustrated by the following story of a little boy.

This little boy, whom we may call John for convenience, was examined with a group of other children selected because of their slow school progress as possible candidates for a special class. He had spent three terms each in the kindergarten, first, and second grades, and was an unsatisfactory pupil in the third grade when he was examined, just before he was ten years old. He had, on the Stanford-Binet scale,

an I.Q. of 78, which seemed, to a rather hurried examiner, quite reasonable. True, a series of performance tests at the same time gave him a mental age within two months of his chronological age, but this the examiner attributed offhand to better ability to deal with concrete things than with abstract. However, an I.Q. of 78 seemed a little high for a special class, so the examiner hunted around for a little more light on the subject. A rather unexpected bit of evidence came to hand. This little boy, during his sojourn in kindergarten, had had two mental tests—one, the Stanford-Binet, given by an examiner whose knowledge of the technique could not be questioned; the other, the Pintner-Cunningham group test. On these two tests, his I.Q.'s were respectively 104 and 101. What shall one say to this: three tests with average scores against his present Binet rating of 78 and his continued failure in school? Shall one dismiss it as just an extreme case of disagreement between tests, or may one find it an opportunity, by an analysis of the psychological facts, for a better understanding of the child?

Perhaps the analysis of a test is not an exciting or highly entertaining procedure, but there is a certain thrill in discovery that makes an explorer endure hardships without complaint. Will you explore with me?

Two tendencies were apparent upon an analysis of John's present Binet test. One tendency was to begin an answer or a response to a certain task with an adequate understanding of it, but to lose the thread of it and trail off to something irrelevant that failed to satisfy the demands of the task. The other tendency was to continue a train of thought started in response to one situation when a different situation was presented, a tendency technically called *perseveration*. Both tendencies show a failure to control his associations as easily as a normal child should. But this is an abnormal rather than a subnormal matter—not enough so, yet, to show itself in any crazy actions or to make his associates think him queer. But the tendency was apparent even in the earlier tests and was more marked in the later one. It was present also in the performance tests, though less evident than in the Binet—doubtless because the concrete material served to keep the problem

before him more specifically. Moreover, when he was six, he had the vocabulary of an average eight-year-old, and when he was not quite ten, the vocabulary of an average twelve-year-old. Besides, he put together without effort the dissected sentences which constitute one of the hardest of the twelve-year tests. And the examiner had been moved to attribute his superior score on performance tests to a lack of facility to deal with tests involving linguistic abstractions! One rarely finds retarded children whose knowledge of word meanings is even average for their chronological age, unless they come from homes of superior culture and have had much special training. These are the psychological facts. The only other factors known about him are that he is an only child, that he has been absent much because of an undefined "nervousness", and that he is shy and timid, although not unfriendly, in school.

How, then, does an I.Q. of 78 fit into the perspective of this picture? I venture to put it this way:

John is an only child who started school with some of the repressions common to only children because they have been compelled to adjust themselves overmuch to adult modes of behavior. Either because of this, or because of an inherent nervous instability, John is recognized as a nervous child to an extent serious enough to keep him some time out of school. John has not learned to play with other children, and he finds it easier to stay on the outside than to go through the painful process of adjustment. Among 40 kindergartners, he is not singled out as remarkable, but only as slow, and so he stays in the kindergarten a second term and yet a third. Each new group of children makes him feel a little more isolated, a little more inferior, a little more discouraged and uncertain of himself, and he reaches the first grade at last without the self-confidence that is so real a spur to success. This process is repeated so that John is more or less confirmed in failure. He doesn't entirely understand it, he becomes more timid, more reserved, more unconsciously preoccupied with his little problem, so that he does not react freely and naturally to a mental problem. His pre-school nervous tendencies become more marked.

The stage is set for one of the innumerable tragedies that

might be averted. John may continue to develop abnormal mental trends until he reaches the state hospital; or he may stop short of that and be only eccentric and apparently dull; or failure may become so habitual that he will give up the problem and take himself at other people's estimate of him, becoming, so far as any mental efficiency is concerned, actually subnormal.

If John's friends can be made to believe in him and to convey their belief to John, if wise guidance can be had to bring him out of his timidity and spur him on to take his part normally in social contacts, if he can have the stimulus of success to cheer him on his way, then John may be saved from the mental wreckage of the community ten or twenty years hence.

Is it not worth while to spend the time and effort necessary to get all the facts, including the low I.Q., into proper perspective, and *after that to see that something is done about it?*

SOCIAL ADJUSTMENT OF RETARDED CHILDREN

A FOLLOW-UP STUDY FROM JANUARY TO JUNE, 1926, OF RETARDED CHILDREN SEEN IN THE HENRY PHIPPS PSYCHIATRIC DISPENSARY BETWEEN JANUARY AND JUNE, 1921 *

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THE study reported here was an effort to investigate the present social adjustment of a group of retarded children examined in the Henry Phipps Psychiatric Dispensary between January and June, 1921. In age the children ranged at that time from two to fifteen years, all but three of them being between seven and fifteen. The group studied excludes cases that showed such features as epilepsy or schizophrenic and post-encephalitic conditions and also the few colored children seen in the dispensary during the period in question, the latter presenting somewhat different environmental problems. Those included, therefore, excepting for their retardation, formed a relatively unselected group of dispensary cases.

* The authors are especially indebted to the Henry Phipps Psychiatric Dispensary for the use of its records and to Dr. Esther L. Richards for her interest and coöperation throughout this study. They wish also to acknowledge the suggestions for treatment of the material made by Dr. Adolf Meyer, Dr. Hans C. Syz, Dr. Phyllis Greenacre, and Dr. Ethel Bowman.

One of the authors (E. F. K.) wishes particularly to make acknowledgment to the psychiatric laboratory of individual and social research established by Dr. Trigant Burrow—a laboratory devoted to studying objectively the habitual subjective states of the individual *within his environment*. Due to work in this laboratory, this author has come to recognize the importance for all studies in social psychology of investigation of the emotional environment as a factor influencing both the data and the investigator.

The very earnest assistance of Miss Mabel Kraus, social worker in the Henry Phipps Psychiatric Dispensary, in making visits and arranging appointments, also needs special mention, as does the hearty coöperation of the superintendents of the various Maryland institutions.

The purpose of the investigation was to find out just what had happened to these children during the five-year period subsequent to their examination—to discover what adaptation had been made in each case and to compare the present status of the child, mental and social, with the status as determined five years ago. Adaptations made during a period of this length may well be considered indicative of what one may expect of individuals with this type of mentality, who, without special training, are at the mercy of the economic and social conditions of our large cities. Although in some of our cases the family had been visited at times by the workers of one or another social agency, none of the children, prior to the first examination, had had the advantage of any sort of special training; neither does special training during the past five years enter as a factor in the adaptations that are studied here. This investigation, therefore, differs from those that have been made in connection with schools that offer special training for the feebleminded (the Training School, Vineland, New Jersey; Rome State School, New York; and the Walter E. Fernald School, Waverley, Massachusetts)—studies that have considered the adaptation of the individual largely in relation to the efficiency of the training given by the institution. But the study by Anderson and Fearing[1] (part of the Mental Hygiene Survey of Cincinnati which deals with the adaptation of retarded children from the public-school system) and the present investigation have many things in common; the purpose was similar and the type of case studied nearly the same. The Cincinnati study, however, is based upon a much larger number of cases and includes individuals who have never had any social or dispensary record, a group that is not touched in the present work. There is a difference also in the age of the subjects, those of the Cincinnati investigation averaging nearly ten years older than those of our group. This makes possible the inclusion of data that were not yet obtainable for the boys and girls of our group. On the other hand, the present study, from the very fact that it deals with a younger, smaller, and,

[1] *A Study of the Careers of 322 Feebleminded Persons*, by V. V. Anderson, M.D., and Flora May Fearing. New York: The National Committee for Mental Hygiene, 1923.

in one sense, more selected group—since in all of these cases there were situations for which dispensary recommendation was sought—offers a slightly different approach to the same problem.

When one considers the large number of slightly retarded children who pass through our clinics and schools each year and the relatively meager information that is available regarding the assimilation of these individuals into the social group as a whole, one recognizes the social significance of adjustment and the need of supplementing the study of individual cases by approaches that offer a more comprehensive treatment of the problem. Studies of this nature, however, face a major difficulty in the absence of control. They necessarily deal with a complex of factors for many of which we have no established standards or norms, no method of evaluation, either of the factors independently or as related to one another. There is thus no fulcrum to give leverage on the problem itself. The present writers have been quite aware of this limitation, but have felt, nevertheless, that such data as have been available are of a certain value in that they suggest tendencies that might form a basis for still further study.

Of the 97 cases with which the study started, 39 were girls and 58 boys. Of these, 29 could not be located. The data presented here, therefore, include only the remaining 68 cases—27 girls and 41 boys—which were studied as completely as time and opportunity allowed. As has been said, the age range was from two to fifteen years. All of those under seven years, however, were cases of conspicuous mental defect and, though very complete data were secured for each, these individuals, from the point of view of this study, form the least interesting group, since they are so low in the intelligence scale as to require constant care and supervision. Unlike the other children of this study—most of whom were brought in by social agencies—the children of this group, four boys and four girls, were referred by other departments of the hospital, especially from the Harriet Lane Children's Dispensary.

These eight individuals differed from the other cases also in the type of social environment from which they came, their

homes being with one exception either average or slightly above average, and further in the fact that present status was the same throughout the group, two of them being in institutions for the feebleminded and the others being cared for at home.

Of the remaining 60 cases, brought in chiefly in connection with social problems, a large number were being investigated with a view to making recommendations for placement. Though some reported backwardness in school as an outstanding feature and a few made complaint of neurotic tendencies, there seemed to be but slight recognition of the many major difficulties of adaptation that were discovered in taking the histories. Thus these cases of maladjustment and retardation probably present a fair sample of the problems to be found in a population like that of Baltimore. The very circumstance of the dispensary visit, however—the circumstance that there was in each of these cases a problem of sufficient importance to necessitate investigation by a social agency—is a selective factor that differentiates this group from that of the Cincinnati study, in which 30 per cent of the cases came from families that had had no social-service record.

The method of examination was that followed in all cases in this dispensary—investigation of character traits, environmental influences, neurotic tendencies, school history, and so forth. Children are also given the Binet-Simon (Stanford revision) intelligence test. Cases in which there is a suspicion of malnutrition, defective vision or hearing, adenoids, or other physical abnormality, are, as a matter of routine, sent to other departments of the hospital for thorough examination. A complete case history is filed. After the examination at the Psychiatric Dispensary, a report is sent to the person or agency through which the child was brought for examination. A few groups of cases have been followed at regular intervals since their first admission to the dispensary, but as these presented special psychiatric features, they were excluded from the group studied here. The majority of our cases, therefore, had not been heard from since their first visit in 1921.

The original I.Q. findings (1921) were used as the basis for

classifying the children as dull, retarded, or defective. No finer differentiation was attempted. It would have been interesting to make a careful restandardization of each case for comparison with the original mental-defect finding. This. however, was not practicable. Some of the individuals, when visited, showed a distinct willingness to coöperate in giving information, but were not willing to return to the dispensary for examination or to repeat the test. Others were scattered throughout Maryland and adjoining states. But in those cases that were restandardized, none showed sufficient variation from the original test to change the grouping made on the basis of the 1921 findings.

Information regarding the social adaptation that these children had made was secured through the coöperation of institutions, social organizations, and parents. A number of cases were returned to the dispensary for reëxamination, and others were visited at their homes or at work.

In the course of the investigation data were secured on five points: (1) the retardation of the child; (2) the environmental setting in which the child had lived and his adjustment at the time of the first visit to the dispensary; (3) the environmental setting during the five years between the first visit and the present study; (4) the social adjustment at the time of the present study; and (5) the school record. In order to handle this material and to determine what relationships existed between these various sets of data, it was necessary to establish certain empirical criteria which could be used as a basis for classification.

For retardation, of course, the criterion established in the Binet-Simon test was at hand and was used, the children being classified on the basis of the I.Q. findings as dull (I.Q. 76–90); retarded (I.Q. 50–75); and defective (I.Q. below 50).

An effort to classify environmental setting or social environment immediately presents difficulties. Though Meyer, Richards, and many others have frequently called attention to the importance of the environment in determining a child's mental and emotional attitudes, we have no experimental evidence as to just what sort of environment offers the individual the most fortunate preparation for later adjustment. We know, too, that many socially maladjusted individuals

have come from homes that appear superficially to offer the greatest opportunity. Thus, at the present time, nothing more than a tentative classification is possible. Nevertheless, the homes in this study, when considered from the point of view of rather obvious advantages to the children in their custody—clothing, food, educational opportunity, care, and so forth— do fall into quite definite groups, and it has been of interest to bring these into relationship with our other findings. For the purpose of the present study, therefore, we arbitrarily established five classes—*very good, good, fair, poor,* and *very poor.*[1]

Briefly our criteria are as follows:

> By *good* we mean a home that is relatively independent, economically and socially, that is in a respectable neighborhood, is kept neat and clean, and is characterized by average sanitary conditions. In such a home the father is a steady worker, earning a good living wage and providing adequately for his family, and there is a consistent interest in the welfare of the children.

Only three of the children included in this study came from homes of this standard. Of these three, two were definitely defective, one of them, at ten years old, being unable to walk or talk, and the other, at seven years, saying only a few words. None of the children of the group studied came from homes above this level—*i.e.,* from a *very good* home in one of the better sections of the city, where the educational, economic, and social standards are well above the average.

> We classed as *fair* homes located in a respectable neighborhood, provided with fairly adequate facilities for sanitation, and kept moderately clean. In these homes the father is not always able to provide for the needs of his family, does not work steadily, and may have periods of drinking. On the whole, however, such homes are relatively self-respecting and not far below what might be considered average in that there is an effort to train and educate the children.
>
> Under *poor* we included homes that are small, overcrowded, and located in a rather questionable section of the city, with poor sanitary conditions and relatively uncared for children. Here one of the parents was usually alcoholic and immoral. In these homes, one finds friction within the family and general maladjustment, often with the parents separating on grounds of alcoholism or sex offense. We also included

[1] At the time of this study, the authors did not know of the "home index" established by Anderson and Fearing. The classification here used, compared with that index, is as follows: good, 18–21 points; fair, 13–17 points; poor, 9–12 points; very poor, 5–8 points.

in the group with poor environments those illegitimate children and orphans who had been shifted about from one home to another.

The last group—that of *very poor* environment—includes homes located in a disreputable region, kept in a filthy condition, without facilities for sanitation, and very crowded. Frequently both parents are alcoholic and live immoral lives and the members of the family are largely dependent upon the help of charitable organizations. Many of the illegitimate children were raised in homes of this type and are therefore included in this group.

The authors are well aware of the inadequacy as well as of the arbitrary nature of such a classification. In spite of these disadvantages, however, it has furnished an approach to the data of this study that has seemed well-justified.

The adjustments found at the time of reëxamination have been grouped under four heads: (1) satisfactory extra-institutional adjustment; (2) fairly satisfactory adjustment; (3) unsatisfactory adjustment; and (4) institutional adjustment (corrective or custodial). The criteria for the extra-institutional groups are as follows:

Satisfactory adjustment indicates either relative independence, with successful self-support and a report of community adjustment, or adaptation in a foster home with promise of eventual independence and community adjustment.

Fairly satisfactory adaptation indicates some earning capacity and regular occupation. This group includes also those cases whose records show a fair average adjustment broken into by occasional periods of difficulty and maladjustment.

All of those who were unable to work regularly, had frequent court records, or showed an attitude of shiftlessness and undependability, were classed as *unsatisfactory*.

None of the entire group made adjustments that could be considered either *excellent* or *very poor*. Though some of the adjustments classed as satisfactory might be thought of as excellent, considering the mental capacity of the child, they could not be classed as very good if judged according to the standards set for normal individuals. On the other hand, as none of these cases was over twenty-one years of age, there was none of the chronic, long-continued delinquency to justify a *very poor* group. There were, of course, some cases of children who had been under institutional care, but who were, at the time of this study, making some sort of extra-institutional adjustment following either parole or discharge. The proportion of these cases, however, was small [1] and as none of

[1] In only two cases was there record of discharge. Nine others had been released on parole, but of these two had been returned.

them had been out of an institution for more than a few months, and as there was, therefore, very little information available to justify further classification, these have been left in the institutional group.

Of the five sets of data, those of school progress are probably least reliable since there was no opportunity to check these with the actual school records or to talk with the individual teachers. The data, therefore, are those given in the case histories. For a few of the children, no school history was obtained. A few others were still in school at the time of this study and for these, of course, we do not know the final school attainment.

The data of this study are presented in detail in Tables I and II. The first of these presents the relation between the degree of retardation and the present social adjustment and shows that in 35, or over half, of the cases the retardation is relatively slight (I.Q. 76–90), that 25 have an I.Q. between 50 and 75, and that only 8 are defective (I.Q. below 50). In other words, we are dealing largely with individuals who, when adult, may be expected to approximate closely or to surpass the level of a 12-year intelligence test—*i.e.*, a level which, according to the Army Alpha examinations and the work of Burr, Healy, and others, is competent to handle unskilled and many skilled jobs.[1] Without doubt the 35 individuals in this "dull" group are no more mentally retarded than large numbers of the city's working population who have never been thought of as especially maladjusted or considered as psychiatric problems. Yet when we turn to the adjustments made by these children during the five years included in this study, we find that only 19 of the 35 are now either self-supporting or so placed as to give promise of becoming so, while 14 have drifted into institutions and in 2 cases the adjustment is unsatisfactory. Of the institutional cases in this group all but 2 are correctional.

In the middle or so-called "retarded" group, where we would expect to find a much smaller percentage making extra-institutional adjustments, we find as satisfactory records for the boys as in the higher group, though a larger

1 "Minimum Intellectual Levels of Accomplishment in Industry", by Emily T. Burr. *Ungraded*, Vol. 10, pp. 108–14, February, 1925.

proportion of the girls were being cared for in custodial institutions. This is understandable, since girls are more readily picked up for sex offenses than are boys. Also, in considering the adaptation of the boys of this group, it must be remembered that usually, in the case of the conspicuously retarded individual, greater allowance is made by those with whom he lives and works.

TABLE I. RETARDATION AND SOCIAL ADJUSTMENT OF 68 CHILDREN

		Social adjustment				
			Fairly	Unsatis-	In institutions	
Retardation	Total	Satisfactory	satisfactory	factory	Custodial	Correctional
Dull [1]						
Boys....	25	5	7	1	2	10
Girls....	10	5	2	1	0	2
Retarded [2]						
Boys....	12	2	4	1	0	5
Girls....	13	2	1	1	8	1
Defective						
Boys....	4	0	0	0	4*	0
Girls....	4	0	0	0	4†	0
Total	68	14	14	4	18	18

[1] The age range of this group was from seven to fourteen, the average age of the boys being 10.6 and of the girls 10. The I.Q.'s ranged from 76 to 90, the average for the boys being 83.7 and for the girls 80.3.

[2] Age range, seven to fifteen; average for the boys 13.5 and for the girls 11.9. Range of I.Q.'s, 52–75; average for the boys 62.3, for the girls 66.

* At home.

† Two at home.

In the case of only one boy of this group (Case No. 4, page 826) did retardation seem to be the predominant factor. This boy had an I.Q. of 52, the lowest of the entire group of 25, all the others reaching 58 or over. Of the girls of this group, 7 had an I.Q. of 70 or over, the three who made a satisfactory or a fairly satisfactory adjustment having achieved scores of 66, 70, and 72 respectively.

It is additional evidence of the empirical validity of the Binet-Simon test that in only two of the individuals of the group did we find an adjustment that seemed conspicuously above that suggested by the original test findings. Of these two cases, one was a boy whom it was not possible to retest because he had been placed in a boarding home in another part of the state. This boy, on his original Binet test, made an I.Q. of only 58, which places him very low in the second

or so-called retarded group, and yet he is at present satisfactorily carrying second-year work in the agricultural high school of the community in which he is living. All reports—and these have been quite thorough and from dependable sources—indicate a capacity far above that suggested by the original Binet test. Such a discrepancy indicates that emotional or circumstantial factors—factors that can be only guessed at, since it was not possible to talk with either the boy or the examiner—entered so largely into the original test that its results failed to give a picture of the boy's ability.

The second case is that of a girl (Case No. 10, page 828) who, according to the original Binet findings, has an I.Q. of only 66, but who has been doing satisfactory work in a training school for nurses. In this case a visit was made and the situation was studied carefully. The girl's attitude was quite coöperative, and though she gave evidence of emotion in her discussion, there was an effort to approach the situation quietly and to give any information that was asked for. A little later she talked more freely and quite spontaneously gave data that cleared up some details which had been confusing in the original history. When it was suggested that we would appreciate it very much if, simply as a matter of coöperation in a scientific study, she would be willing to take again the test given in the dispensary five years before, she immediately became very emotional. She said that she really did not feel that she could do this and the matter was not pressed, since it was felt that an examination under the circumstances would be quite invalid. In this case there is undoubtedly some retardation, but it is probably less than the original test indicates.

Summarizing the retardation findings, we note that there is no marked relation between these findings and the social adaptation findings except among girls of the retarded group of whom a large number—8 out of 13—have become inmates of custodial institutions. According to these data, unsatisfactory adjustment is no more frequent among the more retarded boys than among those of the less retarded group.

The school progress, on the whole, is about what one would expect from the retardation findings. Very few of these children—only four—reached high school and a few (all of those in the lowest group) had no schooling at all. Nearly

half, however, completed the fourth grade and about a fifth reached or passed the sixth grade. In considering these data, we must keep in mind the fact that in city school systems generally, retarded children may be promoted on a basis of age and size rather than on the basis of capacity to handle the work of the next grade. In spite of this, however, the school data seem to corroborate the findings of the Binet-Simon tests and to suggest further that in this group of children we are dealing chiefly with individuals who, though slightly retarded, have a sufficient capacity to handle a certain amount of school work and therefore could take advantage of training adapted to fit them for social and economic independence.

Though the school attendance in practically all cases stopped before completion of the eighth grade, all but one of those individuals who made either *satisfactory* or *fairly satisfactory* adjustment reached or passed the fifth grade at school. It is possible that in some of these cases the public school, ill adapted though it is to the needs of the retarded child, has somehow stabilized those who have stayed longest within its classrooms and has given them a greater facility in their later adjustments, or that those who have had such a facility have remained in school, while others, equally intelligent, have dropped out. It might be suggested that those children who came from better home environments had had correspondingly better school opportunities. Our data, however, do not confirm this, since all of those who reached high school and many of those in the upper grades came from poor or very poor homes, while of those from fair homes, the number who dropped out of school early was proportionally as great as in the other groups. It seems to the authors that the school progress and social adaptation, paralleling one another as they do, are probably both alike dependent upon factors other than retardation which largely determine the child's life.[1]

Table II summarizes the relationship between the social environment in which the child had been trained and the social adjustment that was made at the time of this study. In considering this table, the following points should be

[1] See *The Elementary School and the Individual Child*, by Esther Loring Richards, M.D. MENTAL HYGIENE, Vol. 5, pp. 707–23, October, 1921.

remembered: (1) there was no special vocational training as preparation for economic adjustment; (2) the home environment in some cases remained quite unchanged after the first visit to the dispensary; (3) in other cases there was a marked improvement of environment (according to the classification adopted for this study) following the first visit to the dispensary; (4) it was, therefore, possible to make a comparison of the present adaptation of cases in which an effort had been made to provide better environmental conditions with that of the group in which there had not been this action.

TABLE II. HOME ENVIRONMENT AND SOCIAL ADJUSTMENT OF 68 CHILDREN

		Social adjustment				
			Fairly	Unsatis-	In institutions	
Environment	Total	Satisfactory	satisfactory	factory	Custodial	Correctional
Very poor						
Improved						
Boys....	5	2	1	1	1	0
Girls....	3	2	1	0	0	0
No change						
Boys....	5	0	2	0	0	3
Girls....	4	0	0	1	2	1
Poor						
Improved						
Boys....	7	3	3	0	0	1
Girls....	2	2	0	0	0	0
No change						
Boys....	13	0	2	1	2*	8
Girls....	8	0	1	1	5†	1
Fair						
Improved						
Boys....	1	1	0	0	0	0
Girls....	2	2	0	0	0	0
No change						
Boys....	9	1	3	0	2‡	3
Girls....	4	0	1	0	2	1
Good						
Improved						
Boys....	0	0	0	0	0	0
Girls....	0	0	0	0	0	0
No change						
Boys....	1	0	0	0	1*	0
Girls....	4	1	0	0	3‡	0
Total.....	68	14	14	4	18	18

* One of these cases, though of institutional grade, was cared for at home.
† One of these cases was in a psychopathic hospital.
‡ Two of these cases, though of institutional grade, were cared for at home.

It will be noted that of the fourteen individuals who made satisfactory adjustment, all but two had been placed in an improved environment, and of those two cases one came from an environment that was already fair, and the other from an environment that was good. All of the other cases that made satisfactory adjustment came originally from either poor or very poor homes. Of the fourteen individuals who made fair adjustments five had been placed in improved conditions and four came from fair homes. Of the four cases that made unsatisfactory extra-institutional adjustment, only one had had the advantage of changed environment, while of thirty-six cases which were at the time of this study or had recently been under institutional care, only two had been given opportunity for adaptation in an extra-institutional environment other than that in which they had been raised. Excluding the group of defectives, there are twenty-eight institutional cases, of which only ten are custodial.[1] An effort was made to determine the reasons of commitment to the correctional institutions, but these were so varied and the available records were in many cases so incomplete that they are not included.

A few words should be said concerning the nature of the environmental change. In nearly every case this followed (or attempted to follow) the recommendation made in the dispensary at the time of the first visit. Some of the children were placed in boarding homes, a few were placed with relatives, and a number were adopted or taken into foster homes. It seems significant that all but two of the children who could be considered as having made a satisfactory adjustment at the time of this study were children who had received such special attention.

The data of this table thus corroborate the conclusion of Anderson and Fearing that there is a conspicuous correspondence between the adjustment of the child and the opportunity offered by the environment in which he lives. In other words, of these children, those who were placed in a self-

[1] In the interpretation of this finding it is necessary to bear in mind that Maryland has only one very much overcrowded state custodial institution for the feebleminded.

respecting environment seem, on the whole, to have responded by a development that has not appeared in our other cases.

Although the factor of personality and emotional make-up necessarily enters into all problems of adjustment,[1] there was, in the present study, no effort to make an independent evaluation of this component. Reliable data for personality studies could not have been obtained for all of the individuals of this group, and in many instances the original records would not have furnished an adequate basis for comparison. Such data as were available indicated that many individuals with undesirable personality traits—as, for example, Case No. 2, page 825, and Case No. 9, page 828—were in the group making satisfactory adjustment, while others, who from a personality standpoint would be considered a very fair risk—such as Case No. 8, page 827—became inmates of correctional institutions or made unsatisfactory adjustment.

The influence of a changed environment is seen especially clearly in the detailed case histories. Ten of these, showing various degrees of retardation and different environments, three without improvement during the past five years and seven with improvement, are given herewith:

Case No. 1. Boy, W. M.; age (1921) 13; I.Q. 86.

No childhood diseases; sleep improved after he ran away to the country. Before that he hated to go to bed because of a recurrent fearful dream.

Home environment: Poor.

Illegitimate child, boarded out by the mother while she worked. Adopted at age of one year. At three years of age, when the mother by adoption died, he was placed in an orphanage where he remained until ten years old. Returned to his adopted father, who in the meantime had married again. Remained there for three or four months, but against the wishes of the second wife of his father by adoption, who finally announced that her husband must choose between her and the boy. She accused the latter of lying and stealing. The boy was, therefore, sent to live with another family where he remained for three years and then ran away. He was picked up in a suburban town of Baltimore and when accused of running away, said that he had no home and no parents. Was taken in by a family there who became very fond of him, but who were economically unable to keep him. After he had been with

[1] See *The Contributions of Psychiatry to the Understanding of Life Problems*, by Adolf Meyer, M.D. Address delivered at the celebration of the one-hundredth anniversary of Bloomingdale Hospital, May 25, 1921.

them for several months, they placed him with a friend who was an undertaker, where one of his duties was the cleaning of the funeral cars—work that became very distasteful to him. The undertaker told him that if he ran away again, he would be sent to a near-by correctional school. One morning the boy got up very early, finished his appointed task, and then walked to this school and presented himself for admission. He was not admitted, but the authorities there found a place for him with a family who were interested in him.

School history: Began at seven years. Repeated fourth grade once and fifth grade twice. Was suspended from school after running away. School record as "disorganizer" who was always getting into trouble. Reports that he liked school and liked his teacher. Placed in seventh grade in suburban school.

Change in environment: Improved.

Has lived with families who have shown considerable interest in his welfare and who have provided a comfortable home for him.

Social adaptation: Fairly satisfactory.

Has held several jobs, making advancement each time he changed. Is earning his own living and paying board.

Case No. 2. Boy, W. E.; age (1921) 10; I.Q. 90.

Home environment: Very poor.

Father living and well; drunkard. Mother died at childbirth due to cruelty of husband. Father and three children sleep in one bed; home uncared for.

School history: Started school at seven years. In fourth grade at ten years. Does not know how long he has stayed in each grade.

Change in environment: Improved.

Committed to Children's Aid Society, tried in several homes in the country, but had difficulty on account of quick temper and quarrelsomeness. Disliked school, but showed ability. After death of father, was taken into home of maternal uncle, but proved rather disagreeable. Later placed under guardianship of Boys' Home Society.

Social adaptation: Satisfactory.

Has for several years held position in optical supply house. Is paying his own expenses and taking evening classes in wireless at the Polytechnic High School. Reports indicate good social adjustment.

Case No. 3. Boy, G. W.; age (1921) 12; I.Q. 90.

Illegitimate child, usual diseases of childhood.

Home environment: Poor.

Father living, but unable to work on account of locomotor ataxia. Mother died in 1918. Father and mother never married. Father had another wife and child. Parents drifted about from place to place. Much of the time father was without work.

School history: Started school at seven years, but lived two and one-half miles from school and had to walk; hence was irregular in attendance. In second grade at twelve years of age.

Change in environment: Improved.

Placed with family who own their own farm and are well thought of in their community.

Social adaptation: Satisfactory.

He assists with the work on the farm and is said to be a very good farm hand. An excellent report of his behavior is given by his foster parents. Stopped school in 1925, having completed the seventh grade. He has put $25 in the bank since June of the past year.

Case No. 4. Boy, W. S.; age (1921) 14; I.Q. 52.

Child asphyxiated at birth. Great difficulty in feeding. Teething began at six months, walking at sixteen months, talking at two years. No illness except measles. Enuresis until eight years of age. School nurse reports that he is very subnormal. Has few friends and stays by himself.

Home environment: Fair.

Mother very coöperative. Father and mother living and well; one sister and two brothers. Father works regularly; mother keeps home in good condition.

School history: Left school at fourteen years when in fourth grade.

Change in environment: None.

Social adaptation: Unsatisfactory.

Worked on delivery truck of large department store for one year; then was put in stock room, where he could not handle the work and was laid off. Worked at Commercial Chemical Company for five weeks, where he caused an explosion of a still. Worked as blacksmith's helper for three weeks; was all right in the forenoon, but was too slow in the afternoon. Since that time he has had positions with several large department stores, but was unable to hold them for any length of time. Lives with mother and gives her all but one dollar of his earnings.

This is the only case in which retardation seemed to be the predominant factor.

Case No. 5. Boy, A. W.; age (1921) 10; I.Q. 77.

Walked at nine months; developed normally; general health good; usual diseases of childhood. Report that at three years he fell twenty feet, landing on his head on an asphalt pavement. Occasional enuresis. Free outbursts of temper; restless; very dirty; lies to cover up actions; runs away constantly; court charges for burglary.

Home environment: Poor.

Father alcoholic; killed in an accident. Mother immoral. Meals irregular; home disorderly. Two younger brothers.

School history: In second B grade at ten years; inattentive and frequent truancy.

Change in environment: No extra-institutional improvement.

Tried for short periods in several boarding and foster homes, but could not be kept in any of them. Committed to correctional institution as minor without proper care.

Social adaptation: Correctional institution.

Ran away from institution twenty months after commitment; was returned by mother; was allowed to leave for a visit the following year. Later in the same year was paroled. Two years later he returned to the school voluntarily and asked to stay, but was refused admission. The following day he returned with papers from the court.

Case No. 6. Girl, O. A.; age (1921) 13; I.Q. 84.

Home environment: Fair.

Father dead; mother living and well; one brother and three sisters living and well. Other members of the family are said to be "nervous", but with no definite nervous or mental disease. Father is reported as having been heavy drinker. Since his death the family has been moving constantly.

School history: Started school at seven; repeated the second grade; did not attend school from father's death until 1921.

Change in environment: Improved.

Placed in foster home in small community. The foster mother is a widow of wealth and refinement. The girl has lived there for four years.

Social adaptation: Satisfactory.

Seems to have made perfect adjustment in her foster home. Has completed the sixth grade, but because she was older than the children in her class, could not be persuaded to return. Wrote the second best paper in the county in a "good citizenship contest". Associates with the best people of the community, drives the family car, and is thoroughly contented.

Case No. 7. Girl, H. K.; age (1921) 13; I.Q. 76.

Illegitimate child, neglected and abused by mother.

Home environment: Very poor.

When one and one-half years of age, was adopted by man and his wife with whom she lived until 1918, when the adopted mother became ill and bedridden. During this time the child did most of the work. After the mother's death in 1920, the child slept with her adopted father, who had sex relations with her and generally abused her. Attitude at the dispensary was honest and straightforward. Was poorly nourished and rather undeveloped.

School history: None before 1921.

Change in environment: Improved.

Placed in a boarding home where she helped with the work and had opportunity to go to school. She has been carefully supervised by the society in whose custody she has been.

Social adaptation: Satisfactory.

Completed the sixth grade at school. Is now self-supporting, earning $10. per week with promise of advancement. Likes her work and plans to take night classes at the Y. W. C. A. as soon as she can afford to do so.

Case No. 8. Girl, A. F.; age (1921) 14; I.Q. 64.

No history of nervous disease. Enuresis up to nine years. No stammering or night terrors. Usual diseases of childhood. Easy to train, affectionate; general adaptability good.

Home environment: Poor.

Father and mother both dead; mother said to have been of inferior type; father left mother in 1916. Two brothers and two sisters living and well. After death of patient's mother in December, 1919, patient lived with her aunt for three months. She then secured a position doing

housework and caring for children. Her work was satisfactory, but she did not like it.

School history: Started school at six in first grade; attendance very poor. Stopped school in the third grade at ten years.

Change in environment: No extra-institutional improvement.

Committed to orphan asylum, where she remained until 1923, when she was seventeen. Since then she has been working intermittently.

Social adaptation: Unsatisfactory.

Worked off and on in candy factories, but had difficulty in holding jobs. Did very good domestic work, but only as the spirit moved her. Not inclined to steal money, but would take small trinkets and ribbons used for adornment. These articles would be found hidden. When confronted, the patient would deny the knowledge of the theft. In February, 1926, she ran off and married "the most ignorant kind of fellow, who does not even own two pair of trousers, but is buying an automobile". He does odd jobs of labor, but does not get along. At the present time, she and her husband have scarcely enough money to buy food.

Case No. 9. Girl, M. T.; age (1921) 13; I.Q. 77.

Usual diseases of childhood. Is careless and lazy, but helps about the house. Goes to movies every Saturday night—formerly every night. Dances a little. Regular church attendance.

Home environment: Very poor.

Maternal grandparents moral degenerates. Father a murderer, the black sheep of a good family; died at the age of thirty-three. Mother living and well; low mentality, immoral, irresponsible. One brother with an I.Q. of 141. Home poorly kept. Patient sleeps in room with two sisters and one brother.

School history: Started school at nine years; in fourth grade at thirteen; irregular attendance. Is indifferent to school, but thinks that it is not difficult.

Change in environment: Improved.

Within two months she was tried in several boarding homes, where she was considered very difficult, climbed down the drain pipe to meet men, and was hard to manage. Placed in correctional institution for three months. After discharge was placed in a very good free home, where much interest was taken in her welfare.

Social adaptation: Satisfactory.

Is perfectly satisfied with her home. Was very proud at being taken to buy her own clothes and being allowed to make her own selections without suggestion or criticism. She has withstood the attentions of a neighboring farmer who wishes to marry her. Says she may marry some day, but does not care to now.

Case No. 10. Girl, U. B.; age (1921) 10; I.Q. 66.

Occasional outbursts of temper, seclusive, excessive masturbation, and report of indefinite sex episodes with men. Is careless in personal habits, will not bathe or change clothing. Fairly well developed, pubescent, quiet; very active reflexes, good memory, responses rather slow.

Home environment: Poor.

Since time of father's death, when the patient was three years old,

she has been in charge of a children's aid society which has placed her successively in several different homes. In none of these was her placement entirely satisfactory, and on one occasion, she is reported to have knocked down her foster mother because she refused to let the girl go to school on a rainy day. One year prior to her visit to the dispensary, at the request of her mother, she returned to the home of her mother and stepfather, with whom her sisters and brother were also living. There were many quarrels between the girl and her mother, the latter complaining that the girl did nothing but loaf and accusing her of making engagements to go away with married men in the neighborhood. Home poorly kept, as housework had to be done in the evening because stepfather and mother both worked in a mill, making about $10. each per week. Much conflict with the neighbors, whose children are said to be encouraged by their elders to throw things at the house and to taunt the patient with "having been put away".

School history: Was in seventh grade at fifteen years of age, but attendance was irregular. Is very anxious to continue her school work.

Change in environment: Improved.

Ran away from home and was placed by children's aid society with a family who gave her work caring for their children. Though she felt that she was often considered a servant, she appreciated the interest that was taken in her. She had always been extremely anxious to become a nurse and finally found an opportunity to work in a children's hospital, where she proved so dependable that she was advised to take a regular nurse's training course. One of the smaller hospitals which was in need of nurses gave her the opportunity to try the work.

Social adaptation: Satisfactory.

Patient is well along in her training and though she has not the prerequisites for handling the theoretical work easily, her practical work is considered especially good and she has been able to pass all of her examinations satisfactorily. She has gained in weight and looks extremely well and happy and is thoroughly interested in her work. She has been highly recommended for her perseverence and integrity and has been given every encouragement.

DISCUSSION

The data of this study have placed the emphasis in social maladjustment rather more upon the individual's environment than upon the factor of mental retardation, and that in spite of the fact that the authors, tutored in the view that social maladjustment is frequently an expression of feeblemindedness, expected that their data would show a rather definite correlation between these two conditions. That the influence of the environmental component has appeared so clearly seems to have been due to a particular feature of the investigation. Of the 68 cases, 40 are either making poor extra-institutional adjustments or have become inmates of

institutions. All of these individuals (as well as the remaining 28 cases) test as subnormal in intelligence. In other words, if we had set out to study this group of 40 maladjusted individuals, we should have found subnormal intelligence in 100 per cent of the cases and there would have seemed ample support for a conclusion emphasizing retardation as a predominant factor in maladjustment. But there are also the 28 other individuals whose adaptation would not ordinarily have come under observation. Thus in this investigation, as in that made by Anderson and Fearing, it is the circumstance of setting out with a group whose social adjustment proved to be rather heterogeneous that has led to the recognition of the part that environmental influences have played. For ordinarily we do not investigate the individuals who make adjustment in the community at large, who somehow manage to "get on" in the existing order. It is from the misfits who fill our dispensaries and burden our social agencies that we have the data of our sociological studies, and yet conclusions drawn from this group, with no check-up by means of control groups of supposedly "adjusted" individuals, may be based upon quite unwarranted deductions. In the field of clinical psychology we have often erred in this respect.

The data here collected indicate—and this finding is corroborated by the work of Dr. Bernstein, Goddard, and others who have been interested in the mentally defective—that children of border-line intelligence and from homes presenting conspicuously unsatisfactory features are responsive to the more constructive atmosphere of an environment in which there is greater orderliness and self-respect. Anderson and Fearing have come to similar conclusions. Summarizing the Cincinnati study, they say: "We have been impressed with the fact that those elements that go to make for the failure or success of mental defectives in life are in no sense different from those elements that affect the lives of normal persons. Those same elements of character and personality make-up, those same conditions in the home, and those same factors in training that speak for the successful career of a normal child, bear with equal force on the career of the feebleminded child."

For from his environment the child not only receives training in such habits of orderliness and courtesy as facilitate

living and working in social communities, but in addition to these more obvious habits he assimilates—quite aside from any effort of learning on his part or of teaching on the part of those about him—innumerable emotional attitudes of individuals to one another, within the home, and toward the social institutions of the community. In a lawless home, he absorbs lawlessness; in a disorderly home, he absorbs disorder; in a home where there is constant warfare, he absorbs quarrelsomeness. He is thus subjected constantly to mood reactions and unconscious attitudes, of which objective situations, such as those found in the histories of the present study, are undoubtedly an expression. These form the "social environment" of the individual. Important, however, as these problems of human interrelationships are for a study of this kind, they are not within the scope of either the material or the method of the present investigation.[1]

In emphasizing the importance of the environmental factor, it is not the intention of the authors to underestimate the importance of retardation. That it is one of the determining elements in the lives of these children, cannot be questioned. Whether retarded individuals are equally as dependent upon the conditions of their environment as their so-called "brighter" fellows, or whether they are less able to compensate for unfavorable environmental factors, cannot be concluded from the present data.

It must be remembered, too, that the social-adjustment ratings here given have a basis of only five years, and that, although 42 of the cases were at the time of this study sixteen years of age or over, there were a number (exclusive of the defective group) below fifteen and a few who were only twelve. Thus some had not yet finished the uncertain years of adolescence and only one was married. Another study five years later might find the grouping altered in many ways. But that circumstance—which would probably enable one to recognize in the present data potentialities that had been overlooked—could not alter the fact that at the present time these adjustments and maladjustments are found.

It has been impossible to work with the data of this study

[1] For a further discussion of this subject see *The Social Basis of Unconsciousness*, by Trigant Burrow, M.D. (International Library of Psychology, Philosophy, and Scientific Method.) New York: Harcourt, Brace, and Company, 1927.

without sensing their economic significance. Considered merely in concrete terms of expense, the situation has in it many elements to make us pause, and this quite aside from any sentimental concern over the individual case. It is, we feel, not too much to say that practically every one of these individuals, with the exception of the eight defectives, has inherent capacity for constructive, though perhaps not creative, work. In other words, they are capable—so far as our data go—of a level of performance which would enable them to achieve social and economic independence. But though a relatively small percentage of the group has made progress in this direction, the majority, with apparently equal capacity, are not only deprived of the self-respect that comes with regular and productive occupation, but have records that show attention from various agencies—dispensaries, social-welfare societies, juvenile courts—to say nothing of institutional care, which represent a very considerable expenditure of the time, energy, and money of other individuals —an expenditure that, from the standpoint of productive social endeavor, can be considered only as a loss. That such conditions are sapping the vitality of our communities could probably be readily proved. The proof, however, will avail little until scientific investigation of causes takes the place of our present more palliative approach.

SUMMARY

1. This study, made in 1926, of 68 retarded children (41 boys and 27 girls) seen in the Henry Phipps Psychiatric Dispensary in 1921, was an investigation into the social adaptation of these individuals and into some of the factors that entered into this adaptation.

2. The group was unselected except for the exclusion of colored children, epileptics, and cases diagnosed as schizophrenic or post-encephalitic.

3. All individuals were to some extent retarded. In half of the group, however, the retardation was relatively slight (I.Q. 76 to 90). Only eight were defective (I.Q. below 50).

4. Contrary to expectation, relatively little correlation was found between the degree of retardation and social adjustment.

5. In order to facilitate the handling of the data and the study of the relationships between environmental conditions, retardation, and later social adaptation, a classification of home environments and of social adaptation was established. Of the entire group of children, only 14 made satisfactory adjustments, and of these about one-third came from good or average homes, while two-thirds came from environments that were poor or very poor.

6. Twenty children of the group studied had, during the five years preceding this study, been placed in environments that offered opportunities superior to those in which they had previously lived. Of the 14 individuals who were making satisfactory adjustments at the time of this study, 12 belonged to this group, and of the other 2, one came originally from a good and one from a fair home environment. Of the entire group from poor or very poor homes (47 in all), none of those without improved environment were making satisfactory adjustment and only 5 were making fairly satisfactory adjustment.

7. Over half of the cases were or had recently been inmates of institutions. The defectives were custodial cases. Of the other groups, 18 of the 28 institutional cases were corrective, and only 10 were custodial.

8. The authors conclude that the child's environment must be considered as an important contributing factor in any study of the social adaptation of retarded children.

ABSTRACTS

THE PROVINCE AND SCOPE OF MENTAL HYGIENE. By Mervin A. Durea. *The Journal of Abnormal and Social Psychology,* Vol. 22, pp. 182–93, July-September, 1927.

During the last fifteen years there has been a marked shift in the point of view of mental hygiene. Beginning as a movement largely concerned with improving the care and treatment of the mentally diseased, it has spread into the fields of industry and education and the everyday life of the home, until now its function is no longer regarded as merely ameliorative or even preventive, but as something positive and constructive. This change has taken place so rapidly that the formulation of principles and definitions has not kept up with it; mental hygiene has become an art rather than a science. The generalization that it is concerned with the promotion and maintenance of mental health is hardly definite enough to serve as a basis for scientific procedure.

The study reported here was undertaken in the hope that it might serve as a contribution toward a redefinition of the province and scope of mental hygiene and a reformulation of its principles. The study was carried on by means of the following questionnaire:

1. Should the term mental health or "mental hygiene" be concerned with abnormal or morbid factors alone—feeblemindedness, mental disorder, delinquency, criminality, etc.—their recognition, care, and prevention?

2. Should the biological phase alone of "mental hygiene" be stressed, viz., that the chief function of man is environmental adjustment and good adjustment is efficient living?[1]

In this sense mental hygiene applies almost exclusively to so-called normal individuals—normal in this case meaning any individuals who are not classified as feebleminded, insane, psychopathic, delinquent, criminal, etc., or otherwise in need of supervision.

3. Should both of the aspects of mental hygiene cited in questions 1 and 2 be considered in the field of mental hygiene?

4. In case both phases cited in questions 1 and 2 should be included under mental hygiene, should one phase be stressed more or should they be considered as equal in importance?

   a. Stress on morbid factors.
   b. Stress on biological factors.
   c. Of equal importance.

[1] The use of the term "biological" has been questioned by several respondents. To an extent the criticism is warranted, but since the connotation of the term has been explained in the questionnaire, the writer does not believe that results are vitiated because of a misunderstanding (or perhaps technical misuse) of the term.

5. The following are nine institutions or organizations to which mental-hygiene needs are applicable. Please list these in order of importance, using 1 to indicate most important, 2 next in importance, and so on to 9, the least important.

a. Home, to secure good attitude, examples, atmosphere, etc., for both adults and children.

b. School, to secure good health conditions, understanding by teachers of pupils' personality needs, studies adapted to each pupil's needs and abilities, etc.

c. Industry, to secure good health conditions, harmonious relation between management and employees and among employees, work and workers fitted to each other, understanding for and consideration of the misfit.

d. Courts, juvenile and adult, to secure better understanding by all court officers of the mental, personal, social, and other environmental factors in delinquency and crime. Better consideration of individual needs and of the probable effects of punitive measures.

e. Penal and reformatory institutions, to secure better knowledge by all officials of the individual needs of inmates, better attitude toward them, better classification, employment, and segregation.

f. Hospitals, general and special, almshouses, orphanages, etc., to secure a favorable atmosphere, promote self-respect and self-confidence in the inmates, to develop the best judgments of which they are capable, etc.

g. Church, to secure elimination from its forms and teachings of the mentally unhygienic concepts of original sin and passages which relate to revenge, hate, intolerance, etc.

h. Peoples and nations, to secure lessening of race conceit, prejudices, antagonisms, jealousies, injustices, and desires for revenge, in order that they may understand each other better and thus lessen the liability of wars.

i. Social or welfare work, to secure a broader appreciation of the various social groups with which ameliorative work is done, the types of problems concerned, etc.

6. The following are eleven groups of persons to whom mental-hygiene principles apply. Please list these in order of their importance, using 1 to indicate most important, 2 next in importancee, and so on to 11, the least important.

a. Parents, that they may make good homes, set good examples, wisely guide the development of their children, and avoid injudicious ways and words with them.

b. Children, that they may form the best habits, attitudes, and aims, learn self-understanding and self-control, and acquire such knowledge and ability to use it as will enable them to handle their internal conflicts and adjust themselves well to the conditions of life.

c. Teachers, that they may live their own lives efficiently, understand children, adapt studies to each child's need, and develop the best methods of teaching.

d. Employers and managers of workers, that they may develop favorable conditions and adopt good attitudes toward workers.

e. Employees, that they may be better adjusted to their work, and develop better atttitudes toward their work, each other, their employers, and other official superiors.

f. Physicians that they may understand better the mental factors in their patients' illnesses, recognize the beginnings of mental illnesses, and advise patients more wisely.

g. Clergymen, that they may better understand the consequences of incompatible marriages (sexual and temperamental) in the couples they contemplate joining in marriage, distinguish between sinfulness and illness or other conditions in the self-accusation or other mental or social maladaptation of some of their parishioners, and not undertake any but "moral" or "spiritual" healing without medical direction.

h. Judges, that they may have better understanding of mental and social factors in delinquency and crime and the form of delinquency, know the aid mental clinics can give them, and understand the use of expert testimony.

i. Public in general, that it may take interest in use and support of measures for the promotion of mental health, take a more helpful and understanding attitude toward the mentally ill, and support measures and institutions for the better study and care of mental patients and other poorly adjusted persons.

j. Psychologists, that they may understand the laws of human behavior, the motives back of human conduct, various factors that condition human conduct and adjustment, and what reëducative means can be used to make for readjustment.

k. Social workers, that they may understand the various factors contributory to different kinds of social problems.

7. From your point of view formulate a definition of mental hygiene and list below.

This questionnaire was sent to 262 persons. Of these 109 were administrative heads of psychiatric clinics whose names were secured from the Directory of Children's Clinics in the United States, published by the Joint Committee on Methods of Preventing Delinquency. The names of the other 153 were taken from the 1925 year book of the American Psychological Association, and were selected on the basis of their interest in clinical or abnormal psychology, psychopathology, or psychiatry. The group was thus made up of physicians and psychologists.

Replies were received from 152, or 58 per cent, of the 262—from 64, or 58.7 per cent, of the physicians and from 88, or 57.5 per cent, of the psychologists. The author considers these returns significant for two reasons. One is that so far as voluntary response is indicative of interest in the mental-hygiene movement, over half of the total group showed this interest; the other is that there is no marked difference between the physicians and the psychologists in the amount of interest shown. It would appear from this that the questions raised seemed as important to one professional group as to the other.

The present paper deals with replies to the first four questions only. The replies to the other three are to be discussed later. The tabulations do not include all of the 152 replies; some came in too late to be included, in others the data given were incomplete for certain items, and a few were simply criticisms of the technique used.

On questions 1, 2, and 3, 148 responses were tabulated. There was such unanimity of opinion among both physicians and psychologists on these three questions that a tabulation of the replies according to profession seemed worthless, and they were treated as a group. Only one of the 148 replies to question 1 was in the affirmative; the other 147 answered "No". To question 2, four answered "Yes" and 144 "No". On the other hand, 143 answered "Yes" to question 3, and only five "No". It is evident from this that the consensus of opinion was overwhelmingly against limiting mental hygiene either to abnormal or normal factors alone and in favor of including both factors.

Question 4—the question which factor should be stressed or whether both should be considered of equal importance—was not answered in eight of the 148 replies—the five that answered question 1 or 2 in the affirmative and three others. The tabulation on this question therefore included 140 replies. Of these, eight, or 5.7 per cent, would stress morbid factors, and 49, or 35.0 per cent, normal factors, while 83, or 59.3 per cent, regarded the two as of equal importance. In order to find out whether there was any noticeable difference between the physicians and the psychologists on this point, the replies of the two groups were tabulated separately. Of the 60 physicians represented, two, or 3.3 per cent, would stress the abnormal factors; 21, or 35.0 per cent, the normal factors; and 37, or 61.7 per cent, would give equal importance to both. Of the 80 psychologists, six, or 7.5 per cent, stressed the abnormal; 28, or 35.0 per cent, the normal; and 46, or 57.5 per cent, considered the two equally important. Thus 4.2 per cent more psychologists than physicians would place the stress upon abnormal factors; the same proportion in each group—35 per cent—would stress the normal; and 4.2 per cent more physicians than psychologists consider the two factors of equal importance. This is rather contrary to the popular notion that the chief interest of the physician is the study of serious mental deviations.

The results of the questionnaire, the author feels, correlate well with the tendencies revealed in the literature of mental hygiene at the present time and in such practical manifestations of interest as the establishment of mental-hygiene work with students in schools and colleges and the increasing attention that industry is giving to the subject.

"Realizing the potent rôle that various behavior patterns, habit trends, conduct mechanisms, or environmental conditionings can play in the success or failure, adjustment or maladjustment of the individual life, mental hygiene, influenced largely by dynamic psychology, has come to give more and more attention to the social processes that produce the normal individual. Mental hygiene is concerned with every medium or agency that influences or conditions human behavior.

"To say that there is a lessening interest in the application of mental-hygiene principles to the morbid would be to assume more than this investigation shows. Rather the program has been enlarged to meet greater needs. And may this not be a happy situation? Unwarranted pessimism dictates that to do anything of a constructive nature with the insane, feebleminded, criminal, delinquent, and dependent is hopeless. While not subscribing to this gloomy outlook, yet undoubtedly mental-hygiene work with the morbid or abnormal is fraught with some difficulties and many limitations. That those who are permanently incarcerated should have the best of care needs no argument; that delinquency and crime should be made the object of scientific research with a view to its decrease goes without saying; that dependency should be relieved is obvious; that by the application of sane eugenics an effort should be made to reduce the population of the mentally deficient is almost axiomatic; but with mental hygiene working at its highest efficiency with any of these groups, a certain number of social liabilities is inescapable. Even with the best of curative devices, a large percentage of morbid ailments are irremediable by any form of therapy. Whereas, with mental hygiene taking its point of departure in the initiation of a positive, constructive, preventive program, directed toward the achievement of the normal, well-adjusted, mentally healthy individual, social and economic liabilities are reduced to a minimum . . .

"Whether or not the present study portends a gradually lessening interest in the morbid on the part of mental hygiene is impossible to say. The fact that nearly 25 per cent more of 140 cases reply that the morbid and normal are equal in importance than show preference for normal factors seems to show, at least theoretically, that the greater importance of the normal is not generally recognized. However, it is manifest that the data show an evolution of thinking on the whole movement. Obviously, the initial principles of mental hygiene cannot be used in the wider scope of the movement. In the establishment of a fundamental datum or set of working principles it is very likely that, with years of development to the point of greater scientific accuracy, mental hygiene will recognize separate sets of working principles for the morbid and normal."

DARWIN'S THEORY OF MAN'S DESCENT AS IT STANDS TO-DAY. By Sir Arthur Keith, M.D. *Science*, 66:201–208, September 2, 1927.

This paper, the presidential address delivered before the British Association for the Advancement of Science at Leeds last August, is an evaluation of Darwin's theory of man's origin in the light of the evidence that has been uncovered since the publication, in 1871, of *The Descent of Man.*

Sir Arthur compares Darwin's task in writing this book to the writing of a history of the modern bicycle with no documents or dated records of any kind to go upon—nothing but a jumble of antiquated machines in the cellar of some museum. "By an exact and systematic comparison of one machine with another we could infer the relationship of one to another and tell the order of their appearance, but as to the date at which each type appeared and the length of time it remained in fashion, we could say very little. It was by adopting this circumstantial method that Darwin succeeded in writing the history of man. He gathered historical documents from the body and behavior of man and compared them with observations made on the body and behavior of every animal which showed the least resemblance to man. He studied all that was known in his day of man's embryological history and noted resemblances and differences in the corresponding histories of other animals. He took into consideration the manner in which the living tissues of man react to disease, to drugs, and to environment; he had to account for the existence of diverse races of mankind. By a logical analysis of his facts, Darwin reconstructed and wrote a history of man."

In the fifty-six years that have passed since that history was written, a mass of new data have come to light. It is possible now to fill in many gaps that Darwin had to leave blank and some of the details of his narrative have had to be altered. But the fundamentals of his theory remain unshaken—may indeed be said to have become impregnable.

This is largely due to discoveries that have been made since Darwin's death in 1882. Through fossil remains and stone implements man has been traced back to the beginning of the Pleistocene period, at least 200,000 years ago, and further back into the older and longer period that preceded it—the Pliocene. Ten years after Darwin's death the fossil remains of that specimen of primitive humanity known as the *Pithecanthropus* or ape-man were discovered in strata laid down by a stream in Java during the Pliocene period, while Pliocene deposits in East Anglia have yielded crude stone implements. "If Darwin was right, then as we trace man backwards in the scale of time he should become more bestial in form—nearer to the ape.

That is what we have found. But if we regard *Pithecanthropus*, with his small and simple, yet human brain, as a fair representative of the men of the Pliocene period, then evolution must have proceeded at an unexpectedly rapid rate to culminate to-day in the higher races of mankind.

"The evidence of man's evolution from an apelike being, obtained from a study of fossil remains, is definite and irrefutable, but the process has been infinitely more complex than was suspected in Darwin's time. Our older and discarded conception of man's transformation was depicted in that well-known diagram which showed a single file of skeletons, the gibbon at one end and man at the other. In our original simplicity we expected, as we traced man backwards in time, that we should encounter a graded series of fossil forms—a series which would carry him in a straight line towards an anthropoid ancestor. We should never have made this initial mistake if we had remembered that the guide to the world of the past is the world of the present. In our time man is represented not by one, but by many and diverse races—black, brown, yellow, and white; some of these are rapidly expanding, others are as rapidly disappearing. Our searches have shown that in remote times the world was peopled, sparsely it is true, with races showing even a greater diversity than those of to-day, and that already the same process of replacement was at work. To unravel man's pedigree, we have to thread our way, not along the links of a chain, but through the meshes of a complicated network."

Another mistake that was made in the early stages of the search for man's ancestry was the failure to note the conditions that prevail amongst living anthropoid apes. "We ought to have been prepared to find, as we approached a distant point in the geological horizon, that the forms encountered would be as widely different as are the gorilla, chimpanzee, and orang, and confined, as these great anthropoids now are, to limited parts of the earth's surface. That is what we are now realizing; as we go backwards in time we discover that mankind becomes broken up, not into separate races, as in the world of to-day, but into numerous and separate species. When we go into a still more remote past, they become so unlike that we have to regard them not as belonging to separate species, but different genera. It is amongst this welter of extinct fossil forms which strew the ancient world that we have to trace the zigzag line of man's descent. Do you wonder we sometimes falter and follow false clues?"

Another misconception of man's evolution was the idea that it not only took place in orderly stages, but that at each stage every part of his body—skull, brain, jaws, teeth, shin, arms, and legs—

would become a little less apelike, a little more manlike. "Our searches have shown us that man's evolution has not proceeded in this orderly manner. In some extinct races, while one part of the body has moved forwards another part has lagged behind." Take for example the Piltdown skull and jaw bone, parts of an individual who, according to geographical and other evidence, lived in the opening phase of the Pleistocene period and may be regarded as representive of the people who inhabited England at that date. "The skull, although deeply mineralized and thick-walled, might well have been the rude forerunner of a modern skull, but the lower jaw was so apelike that some experts denied that it went with the human fossil skull at all, and supposed it to be the lower jaw of some extinct kind of chimpanzee. This mistake would never have been made if those concerned had studied the comparative anatomy of anthropoid apes. Such a study would have prepared them to meet with the discordances of evolution. The same irregularity in the progression of parts is evident in the anatomy of *Pithecanthropus*, the oldest and most primitive form of humanity so far discovered. The thigh bone might easily be that of modern man, the skull cap that of an ape, but the brain within that cap, as we now know, had passed well beyond an anthropoid status. If merely a lower jaw had been found at Piltdown, an ancient Englishman would have been wrongly labelled 'Higher anthropoid ape'; if only the thigh bone of *Pithecanthropus* had come to light in Java, then an ancient Javanese, almost deserving the title of anthropoid, would have passed muster as a man."

These examples give some idea of the difficulties that attend the task of filling in the blank pages in the geological record of man's evolution. There are still many such blanks. Man has been traced back to the close of the Pliocene, a period that lasted for at least a quarter of a million years, but it has not yet been possible to follow him through that period. Fossil teeth have been found in Pliocene deposits that may be those of an apelike man or a manlike ape; no definite conclusion can be reached until other parts of their bodies are found. There is the same doubt about the fossil remains of the great anthropoids that flourished during the still older Miocene period. As yet only the most resistant parts of their bodies—teeth and fragments of jaw bones—have been found, and until some lucky chance brings to light a limb bone or piece of skull, it is impossible to say with certainty whether or not some of these fragments represent a human ancestor. But a comparison of the teeth of these Miocene anthropoids with those of primitive man leads inevitably to the

conviction "that in the dentitions of the extinct anthropoids of the Miocene jungles we have the ancestral forms of human teeth".

"It is useless to go to strata still older than the Miocene in search of man's emergence; in such strata we have found only fossil traces of emerging anthropoids. All the evidence now at our disposal supports the conclusion that man has arisen, as Lamarck and Darwin suspected, from an anthropoid ape not higher in the zoölogical scale than a chimpanzee, and that the date at which human and anthropoid lines of descent began to diverge lies near the beginning of the Miocene period. On our modest scale of reckoning, that gives man the respectable antiquity of about one million years."

Geological research has as yet produced no final and conclusive evidence of man's anthropoid ancestry—that is, no remains have yet been found that represent the actual transition stage between ape and man. But there is other evidence that seems to anthropologists convincing proof of an anthropoid stage in human ancestry. "Early in the present century, Professor G. H. F. Nuttall, of Cambridge University, discovered a trustworthy and exact method of determining the affinity of one species of animal to another by comparing the reactions of their blood. He found that the blood of man and that of the great anthropoid apes gave almost the same reaction. Bacteriologists find that the living anthropoid body possesses almost the same susceptibilities to infections, and manifests the same reactions, as does the body of man. So alike are the brains of man and anthropoid in their structural organization that surgeons and physiologists transfer experimental observations from the one to the other. When the human embryo establishes itself in the womb, it throws out structures of a most complex nature to effect a connection with the maternal body. We now know that exactly the same elaborate processes occur in the anthropoid womb and in no other. We find the same vestigial structures—the same "evolutionary postmarks"—in the bodies of man and anthropoid. The anthropoid mother fondles, nurses, and suckles her young in the human manner. This is but a tithe of the striking and intimate points in which man resembles the anthropoid ape. In what other way can such a myriad of coincidences be explained except by presuming a common ancestry for both?

"The crucial chapters in Darwin's *Descent of Man* are those in which he seeks to give a historical account of the rise of man's brain and of the varied functions which that organ subserves. How do these chapters stand to-day? Darwin was not a professional anatomist and therefore accepted Huxley's statement that there was no structure in the human brain that was not already present in that of the anthropoid. In Huxley's opinion the human brain was but

a richly annotated edition of the simpler and older anthropoid book, and this edition, in turn, was but the expanded issue of the still older original primate publication. Since this statement was made, thousands of anatomists and physiologists have studied and compared the brain of man and ape; only a few months ago Professor G. Elliot Smith summarized the result of this intensive inquiry as follows: 'No structure found in the brain of an ape is lacking in the human brain, and, on the other hand, the human brain reveals no formation *of any sort* that is not present in the brain of the gorilla or chimpanzee. . . . The only distinctive feature of the human brain is a quantitative one.' The difference is only quantitative, but its importance cannot be exaggerated. In the anthropoid brain are to be recognized all those parts which have become so enormous in the human brain. It is the expansion of just those parts which have given man his powers of feeling, understanding, acting, speaking, and learning.

"Darwin himself approached this problem not as an anatomist, but as a psychologist, and after many years of painstaking and exact observation, succeeded in convincing himself that, immeasurable as are the differences between the mentality of man and ape, they are of degree, not of kind. Prolonged researches made by modern psychologists have but verified and extended Darwin's conclusions. No matter what line of evidence we select to follow—evidence gathered by anatomists, by embryologists, by physiologists, or by psychologists—we reach the conviction that man's brain has been evolved from that of an anthropoid ape and that in the process no new structure has been introduced and no new or strange faculty interpolated.

"In these days our knowledge of the elaborate architecture and delicate machinery of the human brain makes rapid progress, but I should mislead if I suggested that finality is in sight. Far from it: our inquiries are but begun. There is so much we do not yet understand. Will the day ever come when we can explain why the brain of man has made such great progress while that of his cousin the gorilla has fallen so far behind? Can we explain why inherited ability falls to one family and not to another, or why, in the matter of cerebral endowment, one race of mankind has fared so much better than another? We have as yet no explanation to offer, but an observation made twenty years ago by one on whom nature has showered great gifts—a former president of this association and the doyen of British zoölogists, Sir E. Ray Lankester—deserves quotation in this connection: 'The leading feature in the development and separation of man from other animals is undoubtedly the relative enormous size of the brain in man and the corresponding increase in its activities and capacity. It is a striking fact that it was not in the ancestors

of man alone that this increase in the size of the brain took place at this same period—the Miocene. Other great mammals of the early Tertiary period were in the same case.' When primates made their first appearance in geological records, they were, one and all, small-brained. We have to recognize that the tendency to increase of brain, which culminated in the production of the human organ, was not confined to man's ancestry, but appeared in diverse branches of the mammalian stock at a corresponding period of the earth's history."

Turning again to Darwin, Sir Arthur considers how far he fulfilled the second and more difficult part of the historian's task—that of interpreting events, detecting the causes that brought them about and showing why one follows as a direct sequel of another. To describe the various stages in man's evolutionary history is only the first step; the second is to reveal the processes and controlling influences that have shaped that history and made it what it is. "The evolution of new types of man or of ape is one thing, and the evolution of new types of motor cars is another, yet for the purposes of clear thinking it will repay us to use the one example to illustrate the other. In the evolution of motor vehicles Darwin's law of selection has prevailed; there has been severe competition and the types which have answered best to the needs and tastes of the public have survived. The public has selected on two grounds—first for utility, thus illustrating Darwin's law of natural selection, and secondly because of appearance's sake; for, as most people know, a new car has to satisfy not only the utilitarian demands of its prospective master, but also the æsthetic tastes of its prospective mistress, therein illustrating Darwin's second law—the law of sexual selection. That selection, both utilitarian and æsthetic, is producing an effect on modern races of mankind and in surviving kinds of ape, as Darwin supposed, cannot well be questioned. . . .

"The public has selected its favored types of car, but it has had no direct hand in designing and producing modifications and improvements which have appeared year after year. To understand how such modifications are produced the inquirer must enter a factory and not only watch artisans shaping and fitting parts together, but also visit the designer's office. In this way an inquirer will obtain a glimpse of the machinery concerned in the evolution of motor cars. If we are to understand the machinery which underlies the evolution of man and of ape, we have to enter the 'factories' where they are produced—look within the womb and see the ovum being transformed into an embryo, the embryo into a fetus, and the fetus into a babe. After birth we may note infancy passing into childhood, childhood into adolescence, adolescence into maturity, and maturity into old age. Merely to register the stages of change is not enough; to under-

stand the controlling machinery we have to search out and uncover the processes which are at work within developing and growing things and the influences which coördinate and control all the processes of development and of growth. When we have discovered the machinery of development and of growth, we shall also know the machinery of evolution, for they are the same."

The data necessary for explaining that machinery did not exist in Darwin's day. "Over and over again he declared that he did not know how 'variations' were produced, favorable or otherwise; nor could he have known, for in his time hormones were undreamed of and experimental embryology scarcely born. With these recent discoveries new vistas opened up for students of evolution. The moment we begin to work out the simile I have used and compare the evolutionary machinery in a motor factory with that which regulates the development of an embryo within the womb, we realize how different the two processes are. Let us imagine for a moment what changes would be necessary were we to introduce 'embryological processes' into a car factory. We have to conceive a workshop teeming with clustering swarms of microscopic artisans, mere specks of living matter. In one end of this factory we find swarms busy with cylinders, and as we pass along we note that every part of a car is in process of manufacture, each part being the business of a particular brigade of microscopic workmen. There is no apprenticeship in this factory, every employee is born, just as a hive bee is, with his skill already fully developed. No plans or patterns are supplied; every workman has the needed design in his head from birth. There is neither manager, overseer, nor foreman to direct and coördinate the activities of the vast artisan armies. And yet if parts are to fit when assembled, if pinions are to mesh and engines run smoothly, there must be some method of coördination. It has to be a method plastic enough to permit difficulties to be overcome when such are encountered and to permit the introduction of advantageous modifications when these are needed. A modern works manager would be hard put to it were he asked to devise an automatic system of control for such a factory, yet it is just such a system that we are now obtaining glimpses of in the living workshops of nature.

"I have employed a crude simile to give the lay mind an inkling of what happens in that 'factory' where the most complicated of machines are forged—the human body and brain. The fertilized ovum divides and redivides; one brood of microscopic living units succeeds another, and as each is produced, the units group themselves to form the 'parts' of an embryo. Each 'part' is a living society; the embryo is a huge congeries of interdependent societies. How are their respective needs regulated, their freedoms protected, and their maneuvers timed? Experimental embryologists have begun to explore and dis-

cover the machinery of regulation. We know enough to realize that it will take many generations of investigators to work over the great and new field which is thus opening up. When this is done we shall be in a better position to discuss the cause of 'variation' and the machinery of evolution."

But if we know very little as yet about the system of government that prevails in the developing embryo, we are learning more every year about the system that prevails in the growing body, as it passes from infancy to maturity. "The influence of the sex glands on the growth of the body has been known since ancient times; their removal in youth leads to a transformation in the growth of every part of the body, altering at the same time the reactions and temperament of the brain. In more recent years medical men have observed that characteristic alterations in the appearance and constitution of the human body can be produced by the action of other glands—the pituitary, thyroid, parathyroid, and adrenals. Under the disorderly action of one or other of these glands individuals may, in the course of a few years, take on so changed an appearance that the differences between them and their fellows becomes as great as, or even greater than, those which separate one race of mankind from another. The physical characters which are thus altered are just those which mark one race off from another. How such effects are produced we did not know until 1904, when the late Professor E. H. Starling, a leader amongst the great physiologists of our time, laid bare an ancient and fundamental law in the living animal body—his law of hormones. I have pictured the body of a growing child as an immense society made up of myriads of microscopic living units, ever increasing in numbers. One of the ways—probably the oldest and most important way—in which the activities of the communities of the body are coördinated and regulated is by the postal system discovered by Starling, wherein the missives are hormones—chemical substances in ultra-microscopic amounts, despatched from one community to another in the circulating blood. Clearly the discovery of this ancient and intricate system opens up fresh vistas to the student of man's evolution. How Darwin would have welcomed this discovery! It would have given him a rational explanation to so many of his unsolved puzzles, including that of 'correlated variations'. . . . With such sources of knowledge being ever extended and others of great importance, such as the study of heredity, which have been left unmentioned, we are justified in the hope that man will be able in due time not only to write his own history, but to explain how and why events took the course they did.

"I have attempted", Sir Arthur concludes, "to answer a question of momentous importance to all of us—What is man's origin? Was

Darwin right when he said that man, under the action of biological forces which can be observed and measured, has been raised from a place amongst anthropoid apes to that which he now occupies? The answer is yes! and in returning this verdict, I speak but as foreman of the jury—a jury which has been empaneled from men who have devoted a lifetime to weighing the evidence. To the best of my ability I have avoided, in laying before you the evidence on which our verdict was found, the rôle of special pleader, being content to follow Darwin's own example—Let the truth speak for itself."

BOOK REVIEWS

THE WAR ON MODERN SCIENCE. By Maynard Shipley. New York: Alfred A. Knopf, 1927. 415 p.

SCIENCE, THE FALSE MESSIAH. By C. E. Ayres. Indianapolis: Bobbs-Merrill Company, 1927. 295 p.

> "Man, proud man,
> Drest in a little brief authority,
> Most ignorant of what he's most assured,
> His glassy essence, like an angry ape,
> Plays such fantastic tricks before high heaven
> As make the angels weep."

There is a resemblance between these two books, but it scarcely extends beyond the fact that they both deal with science—not any particular branch of science, but science generally. In plan and content they differ greatly, the first consisting of example, the second of argument. Mr. Shipley mourns as he tells the melancholy tale of the fierce onslaught of the uninstructed. Mr. Ayres, not satisfied with hurling bricks into the midst of the scientists, rushes in among them and lustily lays about him after the manner of those who attended Donnybrook Fair.

It is in the belief that the general public is not sufficiently aware of the widespread and serious nature of the revolt against the teachings of modern science that Mr. Shipley, as president of the Science League of America, has taken the trouble to secure, classify, and present a rather staggering array of facts. The book is really an account of the activities of militant Fundamentalism and one cannot read it and remain unmoved. The author skillfully marshals his facts and presents them in such a way as to leave no doubt that henceforth the efforts of scientific men cannot alone be devoted to the elucidation of the hitherto Unknown. Ignorance and error of a particularly undiscriminating and venomous type must be fought right at home. The enemy is organized, is heavily endowed financially, and seems to be supplied with a corps of demagogues whose appeal is to the primitive emotions, not to intelligence, and whose utterances prove them to be as dishonest, unjust, and even as bloodthirsty as the worst of those who have darkened history with torture and death.

After a general review of the *causus belli* over which the opposing forces of science and Fundamentalism contend, the author gives us a "close up" of the enemy's forces. In these there appear to be at

least two organizations: The Supreme Kingdom and the Bible Crusaders, with the sinister figure of the Klan hovering in the background. While neither group is more than an infant so far as duration goes, it is startling to learn that already hundreds of thousands of dollars are at their command and outposts have been established in a very large number of the states. Many a reader who fondly believes that his particular locality is untouched will be surprised to learn that a member or members of the advisory council of the Bible Crusaders are uncomfortably close at hand.

While the great flood of this organized intolerance has been let loose in the South, the directors of activities promise that no section is to be neglected and outbursts of greater or less importance in almost every state indicate that they are in a fair way to make good their word.

Tennessee is, of course, the state in which these nefarious activities have been most blatantly evident, but Mississippi now has succumbed to the vigorous campaign against scientific teaching. It is interesting to note that had the state legislature been left alone, it would have avoided making itself foolish. Just at the time when the proposed legislation seemed about to fail in passing, a flood of wild, but apparently impressive talk was turned loose by imported propagandists and the legislators hastened to put the shackles on all fair teaching of modern scientific theory. In other states, pressure is being steadily exerted, and it is quite possible that the shameful story may be repeated more than once. Mr. Shipley bases his presentation on properly identified newspaper accounts of these activities, and it is refreshing to note that, with few exceptions, newspaper men, in stating their own opinions, seem fully aware of and are doing what they can to combat this thoroughly disreputable attack on freedom of thought.

Lack of intelligence cannot be the explanation of this movement. Lack of wisdom there certainly is, but the great agent is fear. "Religion, since it has its source in terror, has dignified certain kinds of fear and made people think them not disgraceful. In this it has done mankind a great disservice. *All* fear is bad and ought to be overcome, not by fairy tales, but by courage and rational reflection." These words of Bertrand Russell's are surely true. But how are courage and the sense of security, so necessary for the conquest of fear, to be gained without knowledge of how really innocent of danger is the thing that people fear? The last thing that the Fundamentalists desire is the elimination of fear. It is a wonderful coercive force, and we know full well that, driven by their savage desire for dogmatic dominion, they will do all that in them lies to prevent the people's discovering that "even if the open windows of science at first make

us shiver after the cozy indoor warmth of traditional humanizing myths, in the end the fresh air brings vigor and the great spaces have a splendor of their own". The reading of the book will cause many a one to ponder anew over:

> "This is true Liberty when free-born men,
> Having to advise the public, may speak free,
> Which he who can, and will, deserves high praise.
> Who neither can nor will, may hold his peace.
> What can be juster in a State than this?"

The second is a provoking book. Those who read it will find that it always provokes thought and often exasperation as well. The author sets out to "trim the sails" of the scientists and their worshipers. The job seems to please him, and he enters into it with gusto, armed with keen penetration and a peculiarly irritating type of satire.

The hunt for a savior bringing a new revelation has always been one of the chief preoccupations of mankind, and scientific activities, nowadays so obtrusive and seemingly so potent, have undoubtedly had the effect of drawing to science the fearful trust and blind confidence that people from time immemorial have reposed in the savior who, or which, happened to be in favor. Mr. Ayres makes it his business unceremoniously and ruthlessly to strip the trappings from the new god and disclose it as much the same old thing rigged out in new outer garments and with a different set of oracular pronouncements—"the great constant, superstition, in another guise".

He insists that science, as it is known and worshiped nowadays, is nothing more than "machine technology"—folklore pure and simple, comparable in many respects with the disclosures made by Moses on his descent from Mount Sinai. Considerable time and effort are expended in making the similarity clear, and while one boggles a bit at some of the steps in the argument, one cannot help being stirred to a new and lively train of thought. It would assuredly be granted that much scientific work and its results are quite without present value in the everyday life of men, but since one never knows when some of this seemingly "dead" material may become of immense practical value, the argument of present uselessness can scarcely be used in wholesale condemnation of science and scientific effort. Mr. Ayres sees, in the establishment of research councils and foundations by business men, a particularly crass commercialism that, in assisting university men financially, does so only that it may profit materially; that any one nowadays pursues truth for its own sake only, he believes to be utterly unlikely. The chain of events preceding and following the discovery of Insulin, to choose but one example, should go a long way toward the rebuttal of such a view. In his attempt to prove the

contention that scientific "truths" are nothing more than folklore and part of an international plot among scientists always to interpret the workings of mechanical contrivances in the same way, the author will certainly arouse the ire of all truly scientific men, than whom there are none more distrustful of "facts" as discovered and propounded by brother scientists. They insist on "being shown" not by one investigator and his complacent lieutenants, but by the independent checking up of a score of others who take a fiendish delight in showing up inaccuracies and fallacies, should such exist. Exception will also be taken to the author's vigorously stated belief that a great many scientific discoveries and truths are the adventitious outcome of "fiddling" with machines, weights, measures, glass tubes, and so forth. No one could deny that many valuable and in some cases epoch-making discoveries were stumbled upon almost accidentally. This does not in any way diminish their significance; many apples fell before the particular one that impressed Newton, but no one previously had attached significance to the phenomenon or taken the trouble to inquire further. It would be foolish to infer that all scientific discoveries were mere happenings. The failure to find an explanation and cure for cancer and tuberculosis are cited by the author as instances of the barrenness of frontal attacks on problems. He evidently does not nourish the hope, as others do, that out of the stupendous amount of research done on these problems, a solution will come and by design, not by accident.

There are three excellent chapters on the lure of machines, the kingdom of machines, and the industrial revolution. The thought running through the first two is strongly reminiscent of Butler's *Erewhorn* (referred to at length) and Kapek's *R. U. R.* What the author has to say here leads naturally and logically to his contention that in reality the industrial revolution has not much more than started—is a thing of the future and not of the past. The chapter on dissolution points out that already, and with little realization on our part, some of our supposedly firmly rooted institutions are disintegrating under the insidious influence of the "machine".

For the scientists who, earnestly or with tongue in cheek, attempt to keep peace between science and religion, the author has nothing but scorn. The only thing to do is to relegate religion to Sunday and let it go at that, since a real reconciliation would have to be so general, so philosophical that in it both science and religion would disappear.

One might go on at great length, alternately admiring and "picking holes", or trying to, in this thoroughly readable and thought-compelling book, but this is not justifiable now. We may not be convinced that "in all the affairs of men, science included, the wind bloweth

where it listeth", and in fact the author himself may not be as convinced as he leads us to believe he is. That a great many true things are said, and said well, is sufficient to warrant one in commending the book to all who are not afraid to have their beliefs closely analyzed and sharply challenged.

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THE REPRESSION OF CRIME. By Harry Elmer Barnes. New York: George H. Doran Company, 1926. 382 p.

This book is a careful study of the history of methods used in an effort to suppress crime. After a preliminary chapter on crime in the light of modern social and medical science, the author presents successively the steps in the development of criminal codes and penal institutions from the original 1676 code, the Quaker codes prevailing from 1682 to 1718, and the establishment of the Puritan code in 1718, through the developments in Pennsylvania and New York prison systems, to the present time. He discusses with the cool objectivity of the trained historian the origins and development of prison labor, of trial by jury, and of contemporary prison administration.

The book has three striking features. In the first place, it gives a lot of information that will be new to many people. It is interesting, for example, to realize that until William Penn introduced it in Pennsylvania, imprisonment was not regarded as punishment. Imprisonment was resorted to for the purpose of detention until punishment could be inflicted, but it had evidently not occurred to people to regard confined loafing as painful enough to constitute punishment. Once instituted, imprisonment became more and more prevalent as a punishment in itself, with various modifications such as the introduction of prison labor, which was first made as a result of the activity of American Quakers and other prison reformers. In 1822, however, one Sidney Smith advocated in the *Edinborough Review* that prisoners should be given as monotonous, irksome, and dull a task as possible without opportunity to see the results, with no share in the profits, and "no work but what was tedious". "This genial idea", said Mr. Barnes, "triumphed over the program of the prison reformers and was followed by the orgy of the experiment with the treadwheel and crank . . . so that prison labor in England was set back for half a century by the meddling of those practical and sober souls who had God's ear in the matter of penal administration."

A second notable point about Professor Barnes' book is his frank exposition of the present unsatisfactory state of affairs. In addition

to a survey of the inadequate methods and measures of most prisons at the present time, Mr. Barnes devotes an entire chapter to exposing the faults of the jury system with such penetrating shafts as this: "But even if we had the most accurate testimony, by witnesses of the highest intelligence and undisputed veracity, its value and significance would be practically lost upon the illiterate, inattentive, and distracted jury. Hence the outcome is essentially this: a body of individuals of average or less than average ability who could not tell the truth if they wanted to, who usually have little of the truth to tell, who are not allowed to tell even all of that, and who are frequently instructed to fabricate voluminously and unblushingly, present this largely worthless, wholly worthless, or worse than worthless information to twelve men who are for the most part unconscious of what is being divulged to them, and would be incapable of an intelligent interpretation of the information if they heard it." (Page 313.) Professor Barnes says that he would be quite willing to defend the thesis that, in so far as certainty and accuracy are concerned, the modern jury trial is not a whit superior to the ordeal or trial by battle.

He gives a long list of cases in which justice was sacrificed in the interests of "pinhead jurisprudence" of the sort in which convictions were set aside for such reasons as a misprint or a misspelled word in the indictment.

Most interesting of all to the psychiatrist and to those interested in the advance of the ideas implicit in the mental-hygiene movement is Professor Barnes' frank avowal of the psychiatrist's position with reference to the treatment of the criminal. It is difficult, he says, to find a better example of the inability of the average citizen to learn by experience than is to be observed in "the contemporary hysteria concerning the increase of crime and the accompanying attack upon scientific criminology and penology. . . . The modern criminologist is even more alarmed at the increase of crime than the lawyer and business man, for he knows so much better than they how unnecessary it is and how far we are from having enough social intelligence to introduce an adequate method of dealing with the menace." (Page 637.) Professor Barnes puts into one paragraph a statement of the position of modern psychiatry better than it could be expounded in a whole pamphlet: "The new criminology will delegate the study and treatment of the criminal to a permanent group of experts under the leadership of trained and enlightened psychiatrists. Such a group will not be concerned primarily with the mere legal guilt of the person accused. Guilt of criminal action will be regarded only as a symptom of initial significance. Accusation and guilt will be viewed chiefly as means of bringing a criminal

personality into the custody of scientists. The important question will be the menace of the individual to society and the possibility of so treating him as to eliminate that menace. If it is found that his personality is such as to make it permanent and serious, he will be segregated for life, whether he has committed a multiple murder or stolen a bag of peanuts. On the other hand, many a person who has committed a murder will be committed to a sanitarium for treatment, with the expectancy of his ultimate release to a life of freedom if his motivating compulsive disorder is of the type which promises recovery under treatment." (Page 323.)

Professor Barnes takes the position that it is now as scientifically absurd to talk of capital punishment or any other "punishment" for criminals as it is to discuss punishing tuberculous patients or paretics. This, he indicates, does not mean that the principle of painless extermination might not be used even far beyond the scope of the present death penalty.

Professor Barnes' book is highly critical, but his criticisms are constructive. He proposes a program. He thinks provision should be made for thorough and accurate criminal statistics; for the application of the principles of eugenics; for the improvement of the educational system to include an understanding of the necessity for obedience to law, manual and vocational education for every able-bodied citizen, and efficient methods for the aiding of backward children; for personal hygiene and proper housing and recurrent compulsory examination of children; and for the elimination of slum conditions, of the exhibition of crimes in the moving pictures, and of lurid accounts in newspapers. All these have to do with crime prevention.

For more adequate provision for the apprehension and conviction of the criminal, he suggests that the police system be taken out of politics and made an expert profession and that the energies of the police be reserved, so far as possible, for the discovery and apprehension of the more serious types of criminals rather than the suppression of crap games and petting parties. He advocates a reconstruction of the jury system and far-reaching changes in court procedure, particularly with relation to the rules of evidence. Insanity cases should be taken out of the hands of ordinary juries; criminals should be given the advantage of mental examinations and the results put before the judge.

With reference to the reformation of the criminal, Professor Barnes thinks that the most important thing is a change in public attitude so that we will regard penal institutions as places for such treatment of the criminal as will return him to society determined and equipped

to lead a law-abiding existence or else for detaining him permanently. He advocates the separation of first offenders and veteran convicts. Those convicted of petty offenses should, as far as possible, be kept out of penal institutions, and handled through fines, probation, psychiatric clinics, and social guidance unless there are evidences of potential seriousness. He advocates the administration of institutions by non-political and trained experts, comparable to staffs of physicians and nurses in the best hospitals, with provision for social reëducation, self-government, and labor wages from which the cost of maintenance, reimbursement indemnity, and support for the prisoners' dependents should be deducted. The teaching of a trade to the prisoners he thinks exceedingly important, and to aid in their establishment after discharge from the prison there should be an efficient parole and follow-up system in the hands of experts instead of the present situation characterized by careless indifference, politics, and inquisitorial supervision.

Mr. Barnes says all the things that the progressive psychiatrists, sociologists, and educators would want him to say, and he says them with a background of historical evidence marshaled after the fashion of the historical scholar that he is. As an effective instrument in the education of any one who wants the facts impartially presented, this book is unsurpassed.

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PROBLEMS OF HUMAN REPRODUCTION. By Paul Popenoe. Baltimore: Williams and Wilkins Company, 1926. 196 p.

In spite of the title of this book, the publishers state on its outside cover that it is "a sane and simple interpretation of the known facts of human reproduction for the non-technical reader". The book certainly deals less with problems than with facts. It consists of 196 small pages, divided into twenty-one chapters. Each subject is considered very briefly and consequently incompletely. The book presents in the main what is generally accepted as true regarding the anatomy and physiology of the reproductive system. On the whole the material is as clearly presented as brevity and the absence of illustrations would permit. The best chapter is the one on the determination of the sex of offspring. This rather technical subject is made very clear.

In a number of cases the author has given space to relatively unimportant facts or to theories not generally accepted. In a book of this size, intended for laymen, it might have been better to use the space for the more important or more fully accepted facts. The

author's idea of what to include in so small a book will not coincide with that of a good many clinicians. For example, he gives an entire chapter to spermatoxins, and another chapter to artificial insemination, of which the greater part is devoted to the subject of insemination when the husband is sterile. In the chapter on menstruation he gives more than three pages to a discussion of the improbability of the moon or the tides being the cause of the twenty-eight-day cycle, about three pages to mid-menstrual crises, and a full paragraph to the excretion of a poison in the various fluids of the menstruating woman. In the same chapter he states that "the tendency in colleges and other institutions where large numbers of girls are under the care of a physical instructor (especially if the latter is an unmarried woman) is now not even to excuse a girl from exercise, unless she reports symptoms of discomfort". Although such may exist, we do not personally know of any college where exercise is permitted that would not be approved by competent gynecologists. The statements made by many of the colleges that gymnasium appointments must be kept by all those who are not ill should not be interpreted as meaning that the full exercise program will also be required. Carefully selected exercise or else complete rest in a favorable recumbent posture are the substitutes for more general activity. We believe the author would find the college point of view on the whole even more conservative than his own.

Among the problems well discussed is that of sterility. Many of those matters, however, that are recognized as problems from the biological, sociological, or other points of view are either not stated or no theories regarding their solution are offered. In general the author stops at stating the facts from which problems arise. For example, sex antagonism is discussed in a limited way from the point of view of its causes and purpose, but is dismissed as a biological phenomenon which has persisted because of its utility to the race.

The non-technical reader, for whom the book is intended, will be surprised (and pleased or not, as the case may be) at certain of the author's definite assertions. For example, he states that "if there is no striking difference in the *kind* of mentality women possess, there is a noteworthy difference in the *amount of it*". This is in the first chapter, entitled *Male and Female*. In the chapter entitled *The Weaker Sex*, he states that the male is "born with a constitutional handicap which he cannot, by any possible method, eliminate". If the reader takes these statements at their face value, as universally accepted, undebatable facts, and makes use of them in conversation, he will be likely to find himself in the center of a storm of argument. Anticipating this probable difficulty on the part of his readers, the

author would have done well to fortify them with numerous references to the work of authorities, so that they would at least have an even chance against those who have been informed to the contrary.

Psychiatrists will undoubtedly consider the chapter on happiness in marriage inadequate. The author uses exclusively the results of the very valuable research done by Dr. Katharine Bement Davis and the Bureau of Social Hygiene on the subject of the sex life of married women. Important as these statistics are, there is much non-statistical material on this subject, based on the clinical experience of the great psychiatrists, that might have been mentioned.

FLORENCE L. MEREDITH.

Boston.

THE GEOGRAPHY OF WITCHCRAFT. By Montague Summers. New York: Alfred A. Knopf, 1927. 623 p.

This book, which contains a wealth of new material geographically arranged, is complementary to the author's *History of Witchcraft*, a second volume, as it were, on the same subject. In his previous volume Mr. Summers dealt with general principles, while in the present work he gives particulars. The fascinating material is gleaned from both ancient and comparatively modern manuscripts, records, and other original sources, including much evidence taken from actual witch trials. Frequent reference is also made to the works of other authorities on the subject.

There are generously annotated chapters on witchcraft and magic in Greece and Rome, England, and Scotland. A particularly arresting chapter is devoted to the history of black magic in New England. The sorceries and superstitions of France, Germany, Italy, and Spain are each treated in great detail.

The book will be particularly interesting to students of social phenomena. It contains material illustrative of the various forms of magic that have appeared in the course of the ages. Beginning with the various curious practices of ancient superstition which formed a primitive order of magic, it brings in the more elaborate systems of magic later studied in schools, glossed and codified; goes on to the more modern examples of the art, such as those better known to us through our colonial history; and calls attention to certain present-day practices in various parts of the world where old beliefs and old superstitions still linger.

It is appalling to contemplate the degree to which the belief in magic formerly held the common mind. So firm a hold did it gain, and so universally was it accepted as a fact, that state interference became necessary and the laws that were passed against the practice

of magic or relationships with those who practiced it were apparently most strictly enforced. Offenses became punishable by death, and hundreds of lives were needlessly sacrificed. There was obviously a firm belief that certain persons had the power to transform themselves or others into beasts for one purpose or another, to bring about the illness or death of their enemies or the enemies of another, to cause harm to come to the possessions of another, to foretell events and cause evil events to happen to an individual or company, to influence the actions of another for evil, to have commerce with familiars, to make sacrifices to the Demon or become possessed of the Demon, to make potions and lotions from obscene and foul recipes and to hold innumerable other black secrets of magic.

Rich and poor, young and old, persons of high and persons of low estate figure in the accounts given. The situations involved range from those of the simplest relationships of everyday life to those of the gravest political significance.

With the exception of a few inconsiderable circumstances, the occurrences in one age and in one country may be closely and immediately paralleled in the lore of another. A few illustrations from Mr. Summers' work will serve to illustrate this.

"When the famous conspiracy was formed against Rameses III about 1200 B.C., the official account of the trials mention that a certain high official, Hui, resorted to magic to obtain his ends. He procured from the royal library a book of spells and then set to work to make little figures of men in wax and so succeeded in carrying out all the 'horrible things and all the wickedness his heart could imagine'. He is more than once definitely accused of making these men of wax which should cause the human beings they represented to become paralyzed, helpless, and sick to death. The conspiracy was discovered and Hui, who had made a wax image to bring suffering and destruction upon the king himself, was compelled to commit suicide."

A similar magic use of wax figures comes from a narrative dating about the end of the seventh century concerning King Duffus of Scotland. "A company of hags roasted his image made of wax upon a wooden spit, reciting certain words of enchantment and basting the figure with a poisonous liquor. These women, when apprehended, declared that as the wax melted, the body of the king should decay, and the words of enchantment prevented him from the refreshment of sleep. The figure was destroyed; the witches burned at Forres in Murray; and", the narrative continues, "the king regained his health."

"In 1664 the chief indictment against Christian Green and Margaret

Agar of Brewham, Somerset, was that they had made 'pictures' of wax into which they stuck thorns and needles, whereby those whose figures the models were languished and pined to death, being forespoken from that hour."

In ancient Rome, belief in lycanthropy was implicitly accepted, and Petronius speaks of the Werewolf, giving it the name "Uersipellis". Esthonia, Montenegro, Hungary, Austria, Germany, Spain, Scandinavia, Iceland, Lapland, Finland, all have a hundred legends of werewolves. In France, these monsters were supposed to infest the valleys of Brittany and Burgundy, the Landes, and the mountainous regions of the Cote d'Or and the Cevennes. When detected, the *loup-garou* was sent to the stake. At Dole, in 1573, a certain Gilles Garnier was accused and convicted of devouring a little girl of eleven as well as other children, and was burned alive for abominable crimes of lycanthropy and witchcraft. "Stories of the *loup-garou* are yet told in many parts of France and in many villages there is hated and feared some man or old hag who is commonly believed to prowl the neighborhood forests on a winter's night in the shape of a great grey ravening wolf. It is also believed that demons will adopt this form to scare the chance traveler and drive children to maddening terror."

"The loathsome ingredients yew, privet, aconite, hemlock, the venom of a toad, the flesh of a brigand's parboiled limbs, the skin of a green frog, the blood of an infant, dust from a grave, and the rest can be paralleled over and over again in the confessions of the witches and from the pages of the demonologists."

Shakespeare was not drawing on his imagination alone for the famous formula he attributes to the witches in *Macbeth*. The "slips of yew", "root of hemlock", "sweltered venom", "lizard's leg", "toe of frog", "finger of birth-strangled babe" were used on good authority.

The formula for the "flying ointment" with which sorcerers were frequently wont to besmear themselves before they proceeded to the Sabbat were, according to the hag Gratiadei, an Italian sorcerer, "the Blessed Sacrament, the blood of certain small animals, Holy Water, the fat of dead babies". Three other such formulæ were: (1) *"Du pusil, de l'eau de l'Aconite, des feuilles de Peuple, et de la suye;* (2) *De la Berle de l'Acorum vulgaire, de la Ouintefeuille, du sang du chauve souris, de la Morelle endormante, et de l'huyle;* (3) *De grasisse d'enfant, de sue d'Ache, d'Aconite, de Ouintefeuille, de Morelle, et de suye."* As shown by numbers two and three, in which the blood of bats and babies' fat severally occur, these were apparently favorite ingredients.

"The transformation into cats or the cat disguise is so common as to be proverbial everywhere. At a witch trial in Guernsey in 1563, Martin Toulouff confessed that he had assisted at a Sabbat *'la ou ly avoet chin ou vi chatz, d'ou ly enavoet ung qu estoet noir, qu menoit la dance . . . q ledit chat estoet le diable'.* During the winter of 1718 one William Montgomerie, of Barnside near Thurso a Mason, complained to the acting sheriff 'that his house was several times infested with cats to that degree that he nor his family were in safety to reside there'. On one dark November evening, armed with a dirk and ax, he had rushed out into his yard and dispersed a gathering, as it seemed, of all the grimalkins in Scotland. Though he had killed and wounded several, no traces of blood and no bodies were found in the morning. This aroused suspicion which fastened itself on an old crone, Margaret Nin-Gilbert, who had long borne an evil reputation in the neighborhood. When inquiry was made, Margaret was found in bed with her leg broken and bleeding. She later confessed that she had been present in the home of William Montgomery in the form of a cat that night."

It is impossible to do justice to this scholarly and exhaustive work, almost an encyclopedia, or fully to discuss its implications, in the course of a short review. Certain beliefs which are given credence even to-day, such as the "malicious magnetism" warned against in some of our modern cults and used as a weapon by others, become all the more grotesque in the light of the better understanding of their history gained from Mr. Summers' discussion.

The evidence reeks with the hysteria of diseased, unbalanced, immature minds, a record of ignorance, trickery, lies, and imposture. Surely here was a field ripe for psychiatry.

ALICE E. PAULSEN.

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THE PUBLIC MIND: ITS DISORDERS AND ITS EXPLOITATION. By Norman Angell. New York: E. P. Dutton and Company, 1927. 232 p.

Taking as his text the thought that "when we can explain the baser, sillier part of ourselves, then it begins to lose its power over us", this highly gifted student of public affairs pleads for a training in thinking calmly and wisely about matters now sadly muddled by passion. Because society is more complex than it has ever been, it is more exposed to terrific damage from bad public thinking. Before we can hope to make democracy a success, we must, therefore, face fully the extent and the nature of collective folly. The prevention of war—nay, in view of the destruction wrought by modern campaigning, the very preservation of human society—require us to

realize how seriously the world is now afflicted by unexamined and unquestioned emotions.

Instances of such substitutes for thought the author cites in abundance. In England, for example, when the World War was ended, the major problems, as we can see more clearly to-day, were unemployment, the housing situation, and especially the job of laying the basis of a rational, durable peace. The terms actually imposed at Versailles have since been found to be unworkable. Here and there in 1919 a few men like Norman Angell and Mr. Keynes saw clearly enough that even if the cost of the war were to be saddled upon Germany, there could be no other way for Germany to pay than through selling her goods to the rest of the world. But public opinion clamored for the quite impossible course of crushing Germany and at the same time forcing her to pay in money. As for the other problems before the British people, these were utterly ignored in favor of electing windbags and jingoes who were still playing up the war-time hates.

The problem would be less staggering if "the professors and the parsons" stood out conspicuously in favor of something better than the passions of the mob. But it is impossible to read Mr. Angell's documents without a sinking of the heart at the extremes to which the preachers and the college professors went, and still go, either in whipping up emotions or in merely following the popular passions, on matters where the cool head and the long view are cryingly needed. To make Philip sober see how he looked and acted when he was drunk, Mr. Angell quotes many pages from the history of this generation on the ravings which came from people in high places.

England's experience was that of other countries, too. The facts we all needed to know in war time and after "were just as visible then if we had wanted to see them. We did not want to see them. It is not the facts which have altered; it is our mood and temper." And the fundamental problem is still with us. What part but a destructive one can be played by the usual popular passions in voting on such difficult matters as economic unrest, the policy of the Federal Reserve, government aid for the farmer, the war debts, the World Court, the League of Nations, the crime wave, a Catholic President, relations with Mexico, Russia, and the like?

One instance of how misleading can be the information supplied to people is enough. Mr. Angell quotes from a newspaper story of mob murder too sickening in its details to be repeated here. Then when the reader begins to ask what sense there is in retelling this German atrocity, the author informs him that this is a true account of a lynching in our own country, and asks us whether it would be fair for Europeans to base a hatred of all America on a perfectly true story like this. And yet it is this kind of judgment which is most

frequent in the readers of all the world newspapers. The papers that most feed the appetite for sensations are the ones that sell best.

But for all his experience with the readiness of the multitude to follow illusions, "cold toward fact, but avid for fancy", Mr. Angell has not lost his faith in the power of intelligence. He wants us to keep our heads clear about the ultimate direction toward which the training of home, school, and church should point. As against Professor McDougall, he sides with Professor Richards in believing that education *can* increase intelligence by keeping alive the interest of the pupils in how they think, and in encouraging them to give specific attention to this matter of getting their facts and forming their judgments. (He might have mentioned the work done by progressive schools to-day in this line.) The part played by intelligence is, so far as quantitative relationships go, undoubtedly small; and yet it is precisely to this agency in man's make-up that we must turn for any hope of a saner civilization. The need is pressing enough. People, each of them fairly sane in the handling of his own individual affairs, can go wildly insane on public problems. If the book did nothing more than remind us of this fact as ably as it does, it was well worth the writing.

HENRY NEUMANN.

Brooklyn Society for Ethical Culture.

WHY RELIGION. By Horace M. Kallen. New York: Boni and Liveright, 1927. 316 p.

Over all the world to-day the traditional forms of religion are being challenged by the new ideas, new problems, new institutions created by modern science and technology. The stream of modern life seems to flow past the ancient embodiments of religion, leaving them stranded as things outgrown and outmoded. It is not so much that religion is attacked; it is neglected. Mr. Kallen, a humanist in philosophy and for long years a student of religion, undertakes in this work an analysis of the nature of religion and an estimate of its modern claims and status. He is neither antagonist nor protagonist and is probably correct in thinking that his results will please neither the scientific skeptic nor the religious devotee.

He finds that, historically, religions have dealt with the efforts of human groups to achieve the values of life. Religious phenomena center about birth, marriage, hunger, sickness, drought, passion, war, death, the stress of group life, the dangers of the environment, and the quest of satisfactions of the commonplace needs. There is nothing in this to set the religious quest apart from the general life process. Mr. Kallen discovers the differentia of religion in the fact that tradi-

tionally religions have sought the solution of problems and the satisfaction of needs by manipulation of the supernatural. For this manipulation of the supernatural in times of crisis religions developed special men, institutions, and technique. "It is the business of religious experts to work upon these unseen beings, to speak for them and to them."

Mr. Kallen stresses the crisis quality in religion. "It is a mode of behavior resorted to in times of doubt and uncertainty." This is the key he uses for personal religious behavior. It concerns occasions of divided mind or times when the future is uncertain and one is helpless in the effort to find a way out. The only recourse then is to fall back upon the supernatural.

The need of control of the supernatural explains the function of the church. "Churches are craft organizations of men and women skilled in the manipulation of the supernatural." In the modern world, however, the old religious technique is confronted by a civilization which has learned to meet the needs of life by an entirely new method. Practically every phase of life is covered by the new technique of science and modern industry. The service of the supernatural is progressively restricted. As man has acquired increasing mastery of the world and increased knowledge of his universe, the supernatural tends to disappear. Logically, on Mr. Kallen's interpretation of the special function of religion, this would mean that religion is doomed to disappear—a pre-scientific method of control giving place to the technique of science.

But this is not Mr. Kallen's conclusion. He finds a place still for the supernatural and therefore for religion. In times of stress, under certain appropriate conditions, there flows into the human organism an extra-human electro-dynamic energy which gives new peace, new health, and new hope to him who experiences it. Mr. Kallen does not like to call this cosmic energy "God" since it is not personal, regular, purposive, calculable, or controllable. He prefers the term "mana". But he saves the supernatural, on what may be called a scientific reinterpretation of William James' theory of the subconscious. For that much the traditional theologians will be grateful and they will not hesitate to read into this supernatural all the qualities they need. While conserving God in this denatured sense, Mr. Kallen has little hope for the continued existence of churches, at least as religious institutions, since their ancient function is gone and the maintenance of belief by indoctrination in creed is increasingly difficult.

The book is one of the stimulating contributions of the year in this field. It might have opened a new way for religion but for two influences which shape the organization and interpretation of the

material. The first is the influence of William James; the second an obsession common to philosophers of the western world that religion is largely belief, or theology, or at least commerce with the supernatural. But religion is, as Mr. Kallen sees, a quest for the values of living. It may or may not deal with supernatural beings. Its differentia is that it is a group quest, a shared search for values to be shared. A survey of the religions of the ages shows that religions may take manifold embodiments, but the human need for satisfactions in an unsatisfying world keeps alive the ancient quest. Why should religion die because the old magical, supernatural technique may now be discarded and replaced by the methods of modern science? Our tragic failure is that we have not harnessed science and technology to the shared task and ideal that religion is.

To make religion stand or fall with the supernatural is a prophecy of the doom of religion in its old meaning. The attenuated, incalculable, cosmic visitor which Mr. Kallen substitutes for God can never fill the rôle of the gods of the past. Moreover, an acquaintance with the biographies of the gods makes the effort to demonstrate ontological reality by electro-dynamics seem not only futile, but the weirdest of all our modern forms of apologia.

A. Eustace Haydon.

The University of Chicago.

Child Guidance. By Smiley Blanton and Margaret Gray Blanton. New York: The Century Company, 1927. 301 p.

In this book on child guidance one finds neither startling new ideas nor a sentimental exposition of a panacea for the many problems that arise in childhood, but rather a common-sense discussion of important phases of the formative period. The foreword gives the intended scope and uses of the book: "Many books in this field treat the problem child; but that single phase in which the normal child is the problem—in that each individual child must somehow be led to realize his greatest potentialities—has not been adequately covered." Later we read that "it is not written primarily for benefit of the feebleminded nor the psychopathic-inferior child, nor the court case, nor the potential criminal, but for the normal, healthy little girl. . . ." The authors express the hope that the book will be of use as a supplement to child-guidance clinics, as a substitute for clinics where no clinics exist, as a college text in child psychology, as a text for study and extension clubs, and as a guide for parents of normal children.

There are three divisions of the subject matter, which might be called "Early Childhood", "Parental Guidance", and "Personality

Study of the Child". A portion of a quotation from H. S. Jennings found in one of the early chapters gives the general approach to the subject: "Organisms are like other objects in this respect: what they do or become depends on what they are made of, and on the conditions surrounding them."

Little space is devoted to the nature of the organism, at least from structural and physiological aspects. The simple reflex, the conditioned response, the chain of conditioned responses, and learning through muscle tension are discussed briefly in the chapter *The Original Endowment.* The more important phases of infancy and early childhood are taken up under chapter headings such as *Learning to Eat, The Excretory Functions, Learning to Sleep, Sensory Training, Learning to Walk,* and *Learning to Talk.* These chapters usually deal briefly with proper training and then give a more detailed account of the possible problems that may arise, devoting, for example, over eight of the eleven pages on the excretory functions to enuresis.

In the next portion of the book more emphasis is placed on the parents' responsibility in the socialization of the child which logically follows the habit training of early life. Suggestions are offered for planning a nursery where, to a certain extent, the child's waning omnipotence may be maintained by having possessions of his own and time to play by himself. In addition to the physical aspects of the nursery, a carefully planned régime can be introduced for the benefit of child and parents. As the child matures, he is, according to this plan, told the meaning and significance of the "mysteries"—*e.g.,* birth, death, sexual matters, religion, and so forth. At the same time he must be learning to adjust to the group and to recognize the laws of discipline. Unless these general ideas are followed, the child must sooner or later come into conflict with the group or suffer in that he becomes a "nervous child". In addition to this it is of course necessary to recognize the part played by lack of capacity or unusual ability. The chapter on intelligence deals first with the uses and limitations of intelligence tests, particularly of the Binet-Simon test, and then various types of behavior, resulting primarily from the child's capabilities, are discussed with particular emphasis on the group relationship. The chapter closes with the statement, "The degree of intelligence is fixed. The emotions are the modifiable element. It is in the training of the emotions that we must put forth our best efforts for making the child an effective human being."

The *Study of the Personality of the Child* offers a simple schematic way of charting and recording such traits as aggressiveness, self-confidence, suggestibility, demonstrativeness, gregariousness, social adequacy, attitude toward facts, mood type, emotional responses,

emotional stability, attention type, and attention intensity. As the ideal average and extremes of these traits "are developed in response to the needs of group-living, they can be evaluated from the standpoint of group serviceability. Possessed of one extreme of a trait, the person will be too egocentric, too much for self. With the other extreme, he will be overwhelmed by the group. In any trait the serviceable and healthful norm lies somewhere between." The factors and mechanisms involved in the development of these traits are discussed with frequent illustrations from cases. The discussion of "attitude toward property" covers, for example, foolish unselfishness, selfishness, pilfering, motives for stealing, reasonable generosity, and recognition of the property rights of other people.

The material is well organized and presented in attractive fashion, marked by a freedom from technical or unusual words and absence of involved sentences which might obscure or make doubtful the meaning. To those familiar with children's work the value of this book would lie chiefly in the grouping and presentation of facts. Mention of the more important contributions in this and allied fields would have been of real assistance if the book is to be used as a text for college work or in extension and study clubs, although the authors might well plead that such a procedure would make the book far too bulky. It is a book that can be placed at the disposal of students and parents without fear that unhealthy ideas will be developed or that their attitude toward children will be warped. One might acquire the idea that superficial study of cases and simple changes will invariably eradicate difficulties of long standing, although the general principles found in *Child Guidance* are sound and have stood the test of use in clinical work.

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Philadelphia Child Guidance Clinic.

CRIME AND THE CRIMINAL. By Philip Archibald Parsons. New York: Alfred A. Knopf, 1926. 387 p.

In the preface of this book, Philip A. Parsons describes his effort to present the most significant facts of the crime situation in a single work, designed to meet the needs of layman and college student alike. The success of this effort is at once apparent to the reader. In a scientific, but simple way, the author traces the development of the present crime situation, going back to original sources for just enough information to insure its profitable perusal by the layman. The subject matter is treated in three parts: Part 1, *The Criminal;* Part 2, *Crime;* and Part 3, *Society's Reaction to the Criminal.* Each chapter of each part contains a bibliography of sufficient scope to encourage more intensive study.

In Part 1, the criminal is presented to us in the classifications offered by various criminologists since the time of Lombroso, and these various classifications are discussed. The development of the various changes in the concept of the criminal from the time of the appearance of the "classical" school of Becarria up to the present scientific concept of the criminal as a poorly integrated personality are clearly and concisely presented. To show the importance of mental deviation as a factor in the production of crime, and the futility of present methods of approach to these deviates, much interesting statistical material, and some well-chosen case histories, are presented.

Much of Part 2 is devoted to discussions of physical and social factors that bear important relationships to criminal behavior. This part also presents the common legal classifications of crime and criminals which have been popular in various periods of history. The author shows rather effectively that crime does not exist apart from society and that it is the product of associations and relationships, real or imaginary, within the social group.

After tracing the development of the punitive system, as a result of society's reaction to the criminal, in Part 3, Dr. Parsons concludes: "Traditional theory and practice have brought us nowhere. . . . We need to put the entire matter of criminals and their treatment in the hands of specialists. . . . The first important step to be taken in planning an adequate system of repression is to shift the point of emphasis from the crime to the criminal. . . . This shift in emphasis from crime to the criminal involves sweeping changes in present methods of social defense, including the organization of the police, the collection of evidence, and in methods of going about securing the offender. It involves the entire process of identifying the offender with the offense. Finally, so far as procedure is concerned, it involves the entire process of treatment of the offender after his conviction." He then offers some most timely suggestions as to urgently needed improvements in public attitude and procedure.

While this book offers little that is new in the field of criminology, the wealth of material collected in its pages is so simply and sanely presented in non-technical language that the reviewer unhesitatingly recommends it to lawyer, judge, and administrator of the criminal law, as well as to layman and student, for whom the author tells us it is intended.

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CRIMINAL JUSTICE. By James P. Kirby. (Handbook Series.) New York: H. W. Wilson Company, 1926. 314 p.

Like the other volumes in the Handbook Series, this is a compilation of extracts from current literature. It is composed of articles that should be known to students of the subject. Forty-two extracts are included. Of these fourteen, or one-third, are from the *Journal of the American Judicature Society*, three are from newspapers, eight from reports of crime commissions, three are prepared especially for this volume, two are from the *New Republic*, two from the *Survey*, and one from each of ten other magazines. The articles deal principally with police, jails, courts, crime commissions, and so forth. A forty-three-page bibliography is included, composed of readily accessible and well-known books and articles.

E. H. SUTHERLAND.

University of Minnesota.

THE DELINQUENT BOY—A SOCIO-PSYCHOLOGICAL STUDY. By John Slawson. Boston: Richard G. Badger, 1926. 477 p.

This study is based upon the statistical analysis of certain physical, social, and psychological data collected in four New York State institutions for delinquent boys—New York House of Refuge, State Agricultural and Industrial School, Berkshire Industrial Farm, and the Hawthorne School.

The material was gathered in 1921–24, and, in addition to a preface and an introduction—in which the author clearly delimits his method of approach—there are chapters on intelligence and male juvenile delinquency, mechanical aptitude and male juvenile delinquency, psychoneurotic responses and male juvenile delinquency, physical and psycho-physical factors, and environmental factors, and a chapter given over to conclusions, bibliography, index of tables, and a general index.

The book is devoted to evaluating the contribution of various physical, mental, and environmental factors to juvenile delinquency, the method being largely one of comparison and correlation. Dr. Slawson made no attempt to apply clinical case-study methods in his survey and has kept his report within the field of statistical psychology. The result constitutes an inquiry into possible causal relationships, utilizing a mathematical technic that suggests the work of Goring.

The important features of each chapter are concisely stressed in a series of summaries. Studies of this character (and there have been but one or two in this country) permit generalizations of value

to the sociologist in his working formulations as well as to court and institution officials and the professional educator.

CLINTON P. MCCORD.

Board of Education, Albany, N. Y., and
Albany Medical College.

EUGENICS AND POLITICS. By Ferdinand Canning Scott Schiller. Boston: Houghton Mifflin Company, 1926. 220 p.

This book starts out with a mistaken statement. It says, contrasting eugenics with politics, "Eugenics, on the other hand, is still a science, or a branch of science." A correct way of stating this would be, Eugenics is *not yet* a science or a branch of science, though it has aspirations to be so. In large measure, what prevents it from becoming a science is the moral and ethical propaganda with which it has become tinctured. When a man has a cause to promulgate, regard for scientific truth tends to become somewhat attenuated. The propaganda spirit believes, even if it does not proclaim, that the end justifies the means.

This book belongs to the gloomy school of eugenics. Its main thesis is this: We are rapidly marching downhill, and Heaven knows what will become of us, largely because of the differential birth rate. The differential birth rate is the tendency on the part of the better classes (better socially, financially, and, therefore, biologically) to have a low birth rate, while the worse classes (worse socially, financially, and, therefore, biologically) have a higher birth rate. In the course of time, since like begets like, the better will disappear, and the worse remain—Q. E. D.

In the first place, the differential birth rate will not long pester mankind, since it is only a question of time when all social groups will know the how of birth control, and the birth rate will drop for the wife of the garbage man just as surely as it has dropped for the wife of the mayor. In the second place, it is not at all certain that the defectives of the community have a very high birth rate. A personal, in part published, study of the families from which the feebleminded in the hospitals of Massachusetts come discloses very little, if any, difference between the community birth rate and the birth rate in these families. Moreover, the studies made by Dr. Fernald of the discharged patients from the Waverley institution show a rather low birth rate on the part of the feebleminded who left the institution. Further, it is not at all certain, since it has by no means been proven, that the better socially and culturally are the better biologically. It may even be stated that there is something wrong with the people who are better socially, if they have not enough sexual and parental feeling to have children. Their disinclination

might be called a biological blight, and perhaps such people deserve to disappear, since they are selfish, too comfort loving and too devoted to many things not so biologically important as having children. Even if the better cultural and social classes have more descendants in *Who's Who,* and even if their children average higher in intelligence tests, nothing at all is proven of their biological value. Certainly we may disregard *Who's Who* as an index of biological worth, and the psychological tests merely show that the children brought up under the best conditions, with good training, good food, good schools, and summer vacations, surrounded by an atmosphere of books and culture, do better on tests that measure knowledge than children brought up in the reverse circumstances. If the newer physiological, psychological, and psychoanalytic studies are worth anything at all, it is because they have shown how hugely important very early childhood is for all the rest of life. And possibly the children of the poor (and therefore biologically inferior) would do better than those children who grade better on psychological tests in street fights, in dodging up alleys, in shrewdness and understanding of hard living conditions, in making the most out of little, in endurance—in short, in mere survival under bad conditions. They might well have more knowledge of sex, of perversity and crime, of fighting, and of other things with which their lives bring them into contact.

Schiller's pessimism has at least the virtue of making one novel point. He bemoans the democratic spirit and democratic institutions because they permit the biologically superior of the lower classes to become socially and financially superior and force them into relative sterility, and thus the great source of good qualities in the lower classes is being rapidly used up. I must confess that this is a new point, and as one who has been somewhat bored by the writings of the pessimistic eugenists, I hail this new disaster with something like enthusiasm.

As a matter of fact, the more recent work on genetics and heredity makes all these dogmatic writings seem merely ignorant, even though they are sponsored by such first-class minds as that of the distinguished Schiller. As Jennings has pointed out in *Prometheus* (which ought to be read by every psychiatrist, social worker, and eugenist), the environment can call out qualities of one kind or qualities of another, even to the point of making a race of one-eyed fish out of a race of two-eyed fish, and there is no longer any doubt that bad environmental conditions can injure the qualities of the germ plasm. The man who invented fire, Jennings states, did more to keep certain types of biologically unfit alive than any man since his day, since it warmed up those who otherwise would have died of cold and is responsible for the civilization that keeps weaklings alive. But at

the same time fire altered the fleshy environment in which the germ plasm lives—in fact, bettered the environment in which each germ plasm lives—and thus undoubtedly counteracted whatever ill it may have done. It is true, of course, that feebleminded people ought not to have children, and is also true that superior mentalities ought to have children. There is no real reason at the present time to suppose that the great bulk of the lower grade of social groups are any worse biologically than the smaller bulk of the high grade socially.

It is impossible for me to resist this final shot. I have looked up Ferdinand Canning Scott Schiller. He is like all preachers; he advises by precept rather than by example. He is unmarried!

A. MYERSON.

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SEX HYGIENE: THE ANATOMY, PHYSIOLOGY, AND HYGIENE OF THE SEX ORGANS. By Dr. Julia Kinberg-Von Sneidern and Dr. Alma Sundquist. Translated by Mary E. Collett. New York: Henry Holt and Company, 1926. 114 p.

"An objective treatment of the subject within small compass . . . at once thorough and easily understandable . . . intended to serve as supplementary reading for teachers and for college students of physiology and hygiene."

Sex Hygiene successfully fulfills this purpose, which is quoted from the translator's preface. Its nine chapters are brief and to the point. Starting with the anatomy, physiology, and hygiene of the male and of the female reproductive organs, and continuing with fertilization and embryonic development, pregnancy, delivery, and childbed, the book covers the whole cycle of reproduction. The last four chapters are devoted to the hormones of the sex glands, the venereal diseases, sexual abnormalities, race hygiene, and sexual education.

So far as its anatomy and its physiology are concerned, the book limits itself to its chosen audience—teachers and college students of physiology and hygiene. It presupposes an acquaintance with biology and familiarity with chromosomes, cytoplasm, and the like, and it introduces a fairly abundant scientific terminology in a comparatively brief space. In this respect it is a textbook rather than a popular presentation. The original edition of the book, which appeared fifteen years ago, was intended for parents, but the translator evidently realized that the average parent would find the first chapters difficult reading and therefore did not specially address them.

The portions devoted to hygiene are, however, easily understood by any one and could be read with profit by a larger audience. The suggestions for the care of the body are excellent, not only because of their practical and common-sense nature, but because of the objec-

tive way in which they are presented. The description and discussion of venereal diseases is simple, direct, and informative. The illustrations are excellent.

The book can be recommended not only as supplementary reading for teachers and students of physiology and hygiene, but also for the libraries of schools of social work and of social agencies.

KARL DE SCHWEINITZ.

The Family Society of Philadelphia.

SEX FREEDOM AND SOCIAL CONTROL. By Charles W. Margold. Chicago: The University of Chicago Press, 1926. 143 p.

Professor Margold has set for himself the following task. We quote from his preface: "It is my aim to show that this distinction between sexual relations that result in offspring—and therefore held as social—and sexual relations that do not result in procreation—and therefore urged as individual—is not sound." And, again: "Thus, by both theory and fact, I seek to maintain that due to man's biological, psychological, and social nature, social control is inevitably present in matters of sex conduct."

Whether the author accomplishes this aim had best be left to the individual reader. He presents a very strong sociological argument and a point of view that cannot be overlooked by any one who is seriously interested in this subject.

There are four short chapters in the book. The titles give indication both of their content and their importance: I. *The Justification Offered for Some Radical Sex Practices;* II. *Radical Practices Cannot Be Justified by Merely Biological Data;* III. *The Invariable Presence of Social Control in Man's Sexual Conduct;* IV. *The Intrenched Reality of Group Sex Standards.*

In Chapter I the author quotes freely from the writings of Mr. Havelock Ellis, whom he has chosen for his example of "the radical school". In Chapter II, the principle of social interaction is invoked to show, first, that the sex patterns of the individual are acquired from the social group, and, second, that the sex behavior of the individual is not without its influence upon others.

In Chapter III the author demonstrates that social control is "present even in sex practices which might appear to be, among certain peoples, free from such control". The author's classification of some of the primitive peoples, according to certain of their sex practices and customs, should be useful to other students. This chapter is particularly well done.

Chapter IV shows that even the technique of love-making and courtship, as well as the customs surrounding marriage, can be fully understood only if the group standards are taken into consideration.

In the latter part of the chapter the author shows the value of social control and sex standards, both to the individual and to the group.

There is an excellent bibliography, comprising a total of 486 references, and an unusually good index. The printing and book binding are both attractive.

The author presents his point of view in a manner that indicates a wholesome scientific attitude rather than that of a propagandist. We believe, however, as in many scientific controversies, that the point of view of the author and the point of view of Mr. Havelock Ellis are so divergent that, although they are discussing two aspects of the same thing, these aspects are so far removed from one another as to make the discussion at times appear almost irrelevant. Although both are in a sense discussing the relationships between the individual and the group as they have to do with sex behavior, one views these relationships from the point of view of the individual, while the other takes that of the group. These points of view are of necessity essentially different. They may in many ways be antagonistic. Neither can be safely overlooked. The solution to the problem, both for the individual and for the group, will consist in the resolution of this antagonism.

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A Manual of Individual Mental Tests and Testing. By A. F. Bronner, William Healy, Gladys M. Lowe, and M. E. Shimberg. (Judge Baker Foundation Publication No. 4.) Boston: Little, Brown and Company, 1927. 267 p.

The objects of this book are, first, "to combat the uncritical acceptance of very narrow and simple measurements as offering adequate criteria for judgment of mental capacities", and, second, as a correlate to this, to urge the "utilization of a much wider range of tests, that the human individual may be better known in regard to his various mental capacities, in order to relate his abilities to his possible social, educational, vocational adjustments and achievements". To those who are likely to use the book profitably, it is much more valuable because of its accomplishment of the second of its objectives than because of what it attempts in regard to the first. The outstanding contribution of this volume is its encyclopedic character. Here the advanced student of tests will find a wealth of material carefully organized and clearly presented. The authors' purpose, to which they devote Part II of the book, was to attempt to include every adequately standardized *individual* test of mental ability. A chapter, however, is devoted to inadequately standardized individual tests. Part III contains a discussion of the meaning of the various tests presented

in Part II. Part IV gives a very brief discussion of other fields of testing, including a short chapter on group testing and very brief ones on individual scales, educational, personality, character, vocational, and trade tests. Part V, the appendix, contains a bibliography of 319 titles, a list of publishers and manufacturers of test materials, and two indices, one for names and one for subjects.

The book is a genuine contribution to the field of individual tests. It should serve as a valuable reference book to the worker with mental tests.

NORMAN FENTON.

Ohio University.

MENTAL TESTS IN CLINICAL PRACTICE. By F. L. Wells. Yonkers, N. Y.: The World Book Company, 1927. 315 p.

It has been found so easy to give tests by the wholesale that psychologists have had a tendency to lose sight of the fact that the basic purpose of mental testing is individual analysis. This book gives the latter emphasis. Wells discusses in turn the different tests that are best adapted to clinical use: the Stanford and Kuhlman revisions of the Binet-Simon test, various group tests, performance tests, memory tests, and free-association tests.

The book presupposes considerable acquaintance with the tests and some skill in their administration. The discussions center around various technical details which must be observed if the tests are to be of value to the clinician. The author's method of presentation is to outline some of the basic principles involved in each type of test, to discuss the relative merits of some of the different tests of the type under consideration, to enumerate certain details which may play a part in the application of the results, and finally to present a number of case abstracts which are designed to illustrate the function of the tests in individual diagnosis and treatment. Fifty-five such case abstracts are presented.

The author does not attempt to outline any definite clinical procedure. He is content with the giving of a great number of suggestions which the clinician may use in outlining his own clinical program. In places his suggestions are valuable only if interpreted by one who has a background of experience and intelligence. In other places he seems to presuppose the most extreme inexperience and even lack of intelligence. This latter attitude characterizes especially his chapter on office methods in which he tells what should be purchased for an office—such trifles as paper, penholders, paper clips, erasers, and so on. He actually takes nearly a whole page discussing various paper clips.

In the giving of intelligence tests of both the verbal and the performance type the writer stresses the importance of strict adherence to standardized methods, but continually reminds the reader that the attitude of the subject toward the test situation and toward the psychologist is of importance for the proper evaluation of that subject. In the attempt to study the more intricate personality characteristics, first rank is given to the free-association technique. In the application of the free-association method, the author favors the "analytical interview" method which departs from the standard procedure. In the "analytical interview" a topic is suggested and the subject permitted great freedom of response. He may respond with one word or with a prolonged conversation. Such an interview involves some 250 queries, each of which serves as a point of departure.

The book is to be highly commended to the clinical psychologist in that it emphasizes the importance of regarding the subject who comes for examination as a complete individual who must be studied from every possible angle. It contributes a much needed warning against the tendency to attempt to analyze a subject on the basis of a few test scores. Such scores are suggestive, but must be supplemented by a qualitative evaluation of characteristics and attitudes which are not as yet measurable by tests that can be administered mechanically.

JOHN J. B. MORGAN.

Northwestern University.

SELF-DIRECTION AND ADJUSTMENT. By Norman Fenton. Yonkers, N. Y.: World Book Company, 1926. 121 p.

This author is to be especially commended for putting out, in a small volume, a large number of practial, specific suggestions for developing good habits of study. In his method of attack and choice of illustrations, Dr. Fenton shows that he has intimate knowledge of the problems and psychology of the student.

The purpose of the book is to aid the student to utilize his time and energy efficiently and to become independent and self-reliant in his education. There are no hard-and-fast rules, but many suggestions, leaving the individual to try out several possibilities and select those which best fit in with his peculiar temperament.

The author begins his discussion with an outline of the physical conditions that are conducive to good study habits—proper lighting, comfortable desk and chair, good general health, regular habits, and the like. Stress is laid also on good mental hygiene—the necessity for knowing one's own limitations and facing them without emotion, of searching for one's special abilities and developing them; the importance of forming one's own judgment about instructors and

courses, and of taking a serious attitude toward the job of preparing oneself for a future profession.

Among the more specific topics taken up in detail are ten practical methods of improving one's speed in reading, with considerable discussion of the value of reading rapidly. Note-taking is discussed and illustrated in a clear and helpful manner. The book abounds with many suggestions for learning based upon the outcome of well-known psychological experiments, such as the advantage of reading through an entire poem many times rather than attempting to memorize it verse by verse and enumerations of the types of influence that distract the attention and make concentration difficult. In the closing chapter, a list of books is given as a guide to the student to fields in which to broaden his interest and develop his abilities. Several tests are included in the book which should interest the student and at least familiarize him with the methods employed in personality analysis. It is a book that can be read with profit by any one who is pursuing a course of study, whether at high school, college, extension, or at home.

At times one feels as if the author were somewhat overstressing efficiency in study. While rapid reading is an excellent asset and a great aid in covering the voluminous material assigned to students in their various courses, there is certainly also place for slow, leisurely reading in which one enjoys the style of an artist, pauses to appreciate in full his word pictures, and muses along with him. Perhaps there is no place for such kind of reading in study, but the student should not be left with the impression that reading must always be for the purpose of gaining information quickly.

Some might also object to scheduling one's college or school life as rigidly as the author suggests. Freedom and variety are quite as important for the development of a personality as the careful observance of a proper time and place for everything. Occasionally a little indulgence in the crime of merely "wasting time" is good mental hygiene.

But the criticisms are minor. Indeed, the value of the book is so obvious that criticism must almost descend to quibbling.

SADIE MYERS SHELLOW.

Milwaukee.

THE SOCIAL WORKER IN A HOSPITAL WARD. By Elsie Wulkop. Boston: Houghton Mifflin Company, 1926. 347 p.

"The book does not pretend to do more than indicate what medical-social case-work is." The foregoing statement, which is included in the introduction to Miss Wulkop's book, is the author's. Probably no question is more frequently put to the medical-social worker than,

"Tell me, just what is it you do?" Probably no problem the medical-social worker meets is more difficult to solve than that of putting before the questioner, in terms not easily misunderstood, just what is her function. To stop in the midst of carrying out several plans, making future plans, and meeting emergencies, to define just what "it" is that she is doing is far from being the simplest accomplishment of the medical-social worker's day. Miss Wulkop's book answers well this question. It portrays the medical and social problems presented to the worker in a general hospital and the influence of each upon the other. It shows the types of medical and social treatment required by patients of a general hospital, and the influence of each upon the other. It explains, accordingly, the place of the social worker in a hospital ward in recognizing these social problems of the patients and in applying her theories and experiences to the most beneficial treatment of them, much as the physician applies his knowledge and experiences to the treatment of the diagnoses he makes—and in close coöperation with him.

The book is divided into three parts. Part I includes several pages of description of some aspects of medical-social work. In six pages of her book, Miss Wulkop states the theory of medical-social case-work and states it so clearly and so honestly that those who have had previously but vague notions of the function of a medical-social worker will conclude their reading not only with a better understanding, but with an appreciation of and an admiration for the ambitions of the worker. The social worker who reads these pages will check up on her approach to the problems with which she is dealing and will be encouraged and inspired to meet those of the future with clearer thinking and consequently greater constructiveness.

It is doubtful if any one, having read the introduction, will fail to peruse keenly and with interest the thirty-seven cases presented. Here Miss Wulkop presents the variety of social problems of patients in a hospital ward—and their familes. She does more than present them; she analyzes them and indicates the plan of treatment. The author has placed before her readers actual examples of the medical-social work done at the Massachusetts General Hospital. The cases are grouped according to medical diagnosis—eight of heart disease, eleven of tuberculosis, eight of malignancy, and ten miscellaneous diagnoses. Each group is preceded by a note on social work in cases of the particular disorder. Each case is preceded by an analysis of the medical and social problems therein presented and followed by a comment by the author, and in most instances by a comment by Dr. Richard C. Cabot, on the medical and social treatment given.

In Part III Dr. Cabot calls attention to differences to be expected

in social work done in a community where resources for treatment are highly developed from that in a community where such resources are few in number and variety. It would be interesting to compare the work done on a group of cases that present similar medical and social problems, but in a different section of the country where resources are meager and where the appreciation of the worker's endeavors for her patients is less developed in the minds of physicians and other co-workers. An honest statement of the plans for treatment of these other cases and the results would perhaps be illuminating.

How the Efforts of Physicians Are Stimulated by the Fact That Social Workers Are at Hand to Help, Medical-Social Work Opens a Possibility of Getting at Those Who Most Need, But Will Not or Cannot Ask It, and *Significant Silences in Social Work* are among the interesting headings of the comments by Dr. Cabot that conclude the book.

CORINDA GAGE BACHMAN.

Washington, D. C.

THE YOUNG CHILD AND HIS PARENTS; A STUDY OF ONE HUNDRED CASES. By Josephine C. Foster and John E. Anderson. Minneapolis: University of Minnesota Press, 1927. 190 p.

This volume, by the director of the Institute of Child Welfare of the University of Minnesota and his associate, is a collection of "one hundred brief case histories describing behavior shown by children between the ages of two and six". The book purports to be of value to parents and others, enabling them to gain some insight into the behavior of children, in particular the normal child. Its object, I take it, is to show the influence of home environment in the development of the personality of the child. This purpose is well accomplished in that there are case histories that describe behavior and conduct resulting from over-protection, suppression, failure to train and guide, physical defects, mental deficiency, failure to recognize the gifted child, and so forth. None of the cases cited illustrates an extreme deviation of behavior. In this respect the book is unique. The treatment notes suffer somewhat from the too frequent use of the words *should* and *must,* although the suggestions given are on the whole quite practical.

The index is exceptionally well done. There is no bibliography.

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NOTES AND COMMENTS

Arkansas

The board of charities and corrections, which was created by an act of the 1925 legislature, has been abolished this year, and in its place an honorary board for each of the state's institutions has been created. These honorary boards, eight in number, composed of five members each, appointed by the governor with the advice and consent of the senate, are vested with all the powers and authority formerly vested by law in the board of charities and corrections. They are to select the superintendents of their respective institutions and exercise such powers of supervision and control as are not specifically reserved to the superintendent. The immediate conduct and management of the institutions shall be intrusted to the superintendents. The superintendent of the State Hospital for Nervous Diseases must be a physician skilled in the treatment of mental and nervous diseases.

California

Chapter 639, Laws of 1927, which relates to the practice of medicine, includes neurology and psychiatry as requirements for a "physician's and surgeon's certificate".

Chapter 677, Laws of 1927, amends a section of the Penal Code by adding to the kinds of pleas to an indictment the one "not guilty by reason of insanity". It contains the following new provision:

"A defendant who does not plead guilty by reason of insanity shall be conclusively presumed to have been sane at the time of the commission of the offense charged, provided that the court may for good cause shown allow a change of plea at any time before the commencement of the trial. A defendant who pleads not guilty by reason of insanity, without also pleading not guilty, thereby admits the commission of the offense charged."

A law to provide for the promotion and maintenance of classes in the public schools for children with defective speech was enacted by the 1927 legislature.

A commission to be known as the "Commission for the Study of Problem Children" is created by Chapter 349, Laws of 1927. It contains the following provision:

"It shall be the duty of said commission, in conjunction with the bureau of juvenile research of the Whittier State School, to make a study of juvenile delinquency in the state of California and to

report and recommend to the legislature of the state of California, at the forty-eighth session thereof, a plan for the prevention of juvenile delinquency and the proper care and training of pre-delinquent, delinquent, psychopathic, and maladjusted children, such as, in the opinion of the commission, will be best calculated to remove the causes of juvenile delinquency and provide for the care and training of such children."

A department of social welfare is created by Chapter 49, Laws of 1927. It is to consist of a director of social welfare and six persons, all of whom are to be appointed by the governor. This department succeeds to the duties, powers, purposes, responsibilities, and jurisdiction of the state board of charities and corrections, the department of public welfare, executive board of the department of public welfare, and the children's agents of the state board of control, all of which it supersedes.

An institution for the "confinement, cure, care, and rehabilitation" of drug addicts, to be known as the State Narcotic Hospital, is created by Chapter 89, Laws of 1927. The director of institutions, with the approval of the state board of control, is authorized to provide on the grounds of an existing state institution, or other property owned or acquired by the state, an institutional unit for the isolation and rehabilitation of users of narcotics. The law provides for court commitment and also for voluntary admission to this institution. It also authorizes the transfer to this institution of inmates of any state hospital who have been committed to such state hospital because of drug addiction, provided they are not mentally deranged.

A commission to be known as the "California Crime Commission" is created by Chapter 407, Laws of 1927. The duties of this commission are thus defined in the following extract from the law:

"It shall be the duty of the California crime commission to make a study of the entire subject of crime, with particular reference to conditions in the state of California, including causes of crime, possible methods of prevention of crime, methods of detection of crime and apprehension of criminals, methods of prosecution of persons accused of crime, the entire subject of penology, and, generally, to make a survey of the entire field of crime, and to report its findings, its conclusions and recommendations to the governor and the legislature of California, which will convene in the year 1929."

Connecticut

Chapter 104, Laws of 1927, simplifies the procedure for the dis-

charge of patients from state hospitals for the insane, by making the following provision: "If the officers, directors or trustees of a state hospital for the insane shall be notified by the superintendent or other person in a managerial capacity of such institution that he has reason to believe that any person committed thereto by order of a probate court is not insane or a suitable subject to be confined in such institution, such officers, directors, or trustees may discharge such person." According to the former law, which this new one amends, it was necessary for the officers, directors, or trustees of the state hospital to petition the superior court to order the discharge of the patient, and a copy of the petition had to be served upon the selectmen of the town to which the patient belonged.

Chapter 63, Laws of 1927, provides that the name of any person who shall have escaped from a hospital for the insane and not have been returned to the institution within a year shall be dropped, and that the person shall not be returned to the institution except upon a new commitment.

Idaho

The name of the state institution for feebleminded and epileptic persons has been changed by law to the "Idaho State School and Colony". It was formerly designated the "Idaho State Sanitarium", when it was established by a law of the 1913 legislature.

Illinois

The state colony for epileptics is to be designated by law the "Illinois State Colony for Improvable Epileptics".

Kansas

Chapter 274, Laws of 1927, adds Kansas to the list of states that have enacted laws for the establishment of special classes in the public schools for children who are three years or more retarded in school progress. The following provisions are found in this law:

"That the board of education and the attendance officers in every school district in this state shall ascertain the number of children three years or more retarded in school progress in attendance upon its public schools.

"That the board of education in each school district in this state in which there are fifteen or more such children, three years or more retarded in school progress, in attendance upon its public schools, may establish and maintain a special class or classes to provide instruction adapted to the special needs of such children."

Massachusetts

Chapter 211, Laws of 1927, authorizes the State Department of Mental Diseases to acquire land in Waltham, Belmont, and Lexington for the proposed metropolitan state hospital.

Minnesota

Incurable insanity is made a ground for divorce by the terms of Chapter 304, Laws of 1927. This law states, however, that no divorce shall be granted upon this ground unless the insane person shall have been under regular treatment for insanity and confined therefor in an institution for a period of at least ten years immediately preceding. The law also provides: "In granting a divorce upon this ground, notice of the pendency of the action shall be served in such manner as the court may direct, upon the nearest blood relative and guardian of such insane person, and the superintendent of the institution in which he is confined. Such relative or guardian and superintendent of the institution shall be entitled to appear and be heard upon any and all issues. The status of the parties as to the support and maintenance of the insane person shall not be altered in any way by the granting of the divorce."

Nevada

Chapter 96, Laws of 1927, which amends the divorce law, adds to the list of causes for divorce insanity existing for two years prior to the commencement of the action. Before granting a divorce the court shall require corroborative evidence of the insanity of the defendant at that time. A decree granted on this ground does not relieve the successful party from contributing to the support and maintenance of the defendant, and the plaintiff must give bond therefor in an amount to be fixed by the court.

Ohio

An act of the 1927 legislature provides for expert medical witnesses when a defendant who has been indicted claims the existence of insanity as a defense. The judge of the trial court is authorized to appoint one or more disinterested qualified physicians, not exceeding three in number, to testify as experts at the trial of such person.

A joint resolution of the 1927 legislature memorializes Congress to enact legislation at the earliest possible moment for additional hospital facilities in Ohio for veterans of the World War, including appropriations for increased facilities at the neuropsychiatric hospital at Chillicothe, and for the erection of the greatly needed three-unit hospital for neuropsychiatric, tuberculous, and general and surgical cases in northern Ohio.

South Dakota

The sterilization law of this state was amended by a 1927 act of the legislature. It changes the period between the serving of notice to at least fifteen days, instead of twenty days. In the former law no operation could be performed except upon a full hearing as provided for in a 1921 law. In the new law, unless written demand for a hearing is served upon the superintendent of the institution, after due notice has been given that the operation is to be performed, together with notice of the right to have a hearing by making written demand therefor, the operation shall be performed without further proceedings.

Tennessee

A committee of five to examine into the conditions and imperative needs of the state charitable institutions, including the three state hospitals for mental diseases and the school for the feebleminded, has been authorized by the 1927 legislature.

Utah

Chapter 36, Laws of 1927, authorizes the superintendent of the Utah State Hospital to receive, without commitment, for a period of not more than five days, any person whose case is certified by two physicians to be one of violent or dangerous insanity or of other emergency. This law also provides for commitment for observation for a period of thirty-five days. Another new provision allows the superintendent of this hospital, when requested by a physician, or a member of a board of health, a county commissioner, a sheriff, or a police officer, to receive for a period not exceeding ten days any person needing immediate care and treatment because of mental derangement. The superintendent may, without order of a judge, receive for not less than thirty days any person whose case is certified to be one of alcoholism or drug addiction. In the same law the name of the state hospital is changed to the "Utah State Hospital".

Washington

Chapter 78, Laws of 1927, repeals the following section of a law enacted in 1909:

"It shall be no defense to a person charged with the commission of a crime that at the time of its commission, he was unable by reason of his insanity, idiocy, or imbecility to comprehend the nature and quality of the act committed, or to understand that it was wrong; or that he was afflicted with a morbid propensity to commit prohibited acts; nor shall any testimony or other proof thereof be admitted in evidence."

Report on the Legal Aspects of Psychiatry

For several years the Committee on the Legal Aspects of Psychiatry of the American Psychiatric Association has been at work on a report that would represent the consensus of opinion in the association on the various phases of psychiatry's relation to the law. A report based upon comments from the membership was submitted at the Eighty-second Annual Meeting of the Association in New York, June, 1926, and was referred to the council.[1] At the annual meeting this year in Cincinnati, a revised report, amended in accordance with suggestions from the council and other sources, was submitted to the association and unanimously adopted. This report is given below.

The committee felt that the problem assigned them was not merely one of what we as psychiatrists should recommend to the lawmakers in regard to bills regulating expert testimony, but was one of reinterpreting to society the function and the objectives of the psychiatrist, particularly in so far as these concern the type of behavior which is technically and popularly regarded as criminal. The committee felt that it was exceedingly important to divert the attention of the public from the relatively minor issue of *alienistics* to the major issue of *psychiatrics*.

In the practical application of psychiatry to problems of criminal law, the prevalent concepts of tradition and long usage conflict sharply with psychiatric attitudes. Popular theories of retribution and established methods of dealing with offenders almost entirely prevented a scientific envisagement of crime until recently when psychiatrists, in spite of their original limitation of field, discovered and demonstrated that types and trends of abnormal psychology extended far out from the asylum into the courtroom, school, and home. Psychiatric experience and technique were found equally applicable to the irascible employee, the retarded school child, the persistent stealer, the compulsive drinker, the paranoid murderer, and textbook cases of epilepsy, melancholia, and schizophrenia. Faced with the legal partitions of misbehavior into "insane" and "criminal", psychiatrists found themselves with no technical interest in or agreement with these partitions, but with a driving concern in all the unpropitious trends of human character, with all acts, thoughts, emotions, instincts, and adaptations, either socially or individually adverse. Some of these constitute committable "insanity", some of them do not; but all of them are psychiatric problems.

Behavior disorders classed as crime, therefore, interest the psychiatrist scientifically. He recognizes the administration of criminal justice to be a social problem entrusted to the legal profession and desires to aid that profession in the most intelligent and effective performance of what is perhaps the most difficult of all social duties. Granted a position of neutrality and objectivity rather than a forced partisanship which misrepresents and embarrasses him, he may inform the court as to the scientific findings in a specific case, and advise relative to its best ultimate disposition.

[1] For this report, see MENTAL HYGIENE, Vol. 10, pp. 883–88, October, 1926.

The psychiatrist cannot, however, make affirmations or denials with respect to metaphysical or legal matters concerning which he does not have scientific information. This includes the matter of "responsibility" which is so often raised. This probably means the capacity to change one's conduct in response to the direction of certain painful associations and the legal notion implies a power of volitional reasoning with respect to a contemplated act and the capacity to withhold from that act when and because it is known to be considered wrong legally and morally. Of course this is not the sense in which the public understands it or uses it. In the latter case it is merely an echo, the crystallization of primitive reactions known as talion law. There was a time when even inanimate objects were commonly held to this kind of accountability. If a man tripped over a chair and injured himself, it was "responsible" and must be punished by being broken or burned. Until comparatively recent times animals were held responsible for injuries they committed. But ultimately inanimate things and animals came to be exempted from the ritual of responsibility, and slowly but progressively children, idiots, and finally most of the "insane" were likewise exempted. Various curious tests then had to be decided upon to determine the "responsibility" of persons suspected of "insanity" (i.e., of an "irresponsible insanity"). Once they were compared in appearance and conduct with wild beasts, later with the mentality of a fourteen-year-old child. This was actually the criterion of "responsibility"! Current even to-day in many states is the slightly less hoary "right and wrong" test, persisting in spite of common knowledge that people are actuated by various compulsions to do things they themselves regard as wrong in the most shameful sense. Psychiatrists realize that the capacity to feel remorse or to fear consequences does not imply power to control conduct.

The psychiatrist then is disqualified both by reason of his training and experience and by reason of his point of view from testifying with reference to the individual responsibility of an offender for his acts. There is furthermore good legal reason why no psychiatrist should be asked such a question, or the question as to whether a man knows right from wrong. The psychiatrist is a witness, not a judge or jury. These are questions that a jury must answer, on the evidence before them, which ought to include the evidence of psychiatrists, as to the facts which their examination of the defendant has revealed to them, and as to their opinion, if any, on the question, "Is he mentally capable of knowing that his act was forbidden and punishable?" If not capable, obviously the jury will find no responsibility, but as the law is, the decision of responsibility, hence of capability, rests with the jury, and for a lawyer to ask a psychiatrist to decide responsibility should give him the right to decline to answer.

With reference to punishment, the difference in attitude between informed psychiatrists and that crystallized in contemporary legislation and case law may be briefly expressed as follows:

It cannot be seriously denied that fear plays an important rôle in deterring most persons from the commission of legally prohibited acts. It is the contention of psychiatry, however, that the motive of fear is not the only motive of conduct, lawful or unlawful. In accordance with this view, therefore, a rational program for the administration of

criminal justice must recognize other means of coping with anti-social conduct than the simple appeal to the fear emotion. As long as the law confined itself to a reliance upon fear as the principal deterrent force, there was not much need of psychiatry. With the increasing recognition of the complex mental factors which enter into the commission or failure to commit a certain act, however, psychiatry and psychiatrists must necessarily be drawn into a rational administration of justice; and this is true not only in those cases in which a definite mental disorder, be it disease or defect, is present, but in the general run of cases. For only by recognition of the motives behind criminal conduct can the treatment prescribed by the judge be intelligently calculated to protect society and rehabilitate the criminal, if possible, at the same time. Moreover, only through the aid of trained psychiatrists, assisted by psychologists and sociologists, can those forward-looking reforms in the administration of criminal justice, such as probation, the indeterminate sentence, or parole, be effectively administered.

In a word, *individualization is necessary on the part of the court and other institutions dealing with offenders, and rational individualization must rest on a recognition of those mental and social factors involved in the criminal situation which make each crime and each criminal an unique event.* The psychiatrist seeks for the subjects of his study, not retributive action, but diagnosis and scientific attempt at therapy, plus the protection of society. This, in a sense, is an "inhuman" attitude in that it is a departure from the instinctive mechanism that rules most of humanity; the clamor for vengence is more "human". But treatment may sometimes be as painful as the sacrifice prescribed by the legal ritual. Opening a boil or setting a fracture may be painful, and the psychiatrist, too, may prescribe painful treatment, but it is never retributive punishment, and never a program basing its efficacy on the fallacy that fear is the sole determinant of human behavior.

The modern psychiatric position holds:

1. That the psychiatrist's chief concern is with the understanding and evaluating of the social and individual factors entering into failures in human life adaptations.

2. That crime is a designation for one group of adaptation failures, and hence falls definitely within the focus of psychiatry, not excluding, of course, certain other branches of science.

3. That those who commit crimes are proper subjects for scientific study and analysis with reference to their antisocial propensities.

4. That this study includes a consideration of the hereditary, physical, chemical, biological, social, and psychological factors entering into the personality concerned throughout his life as well as (merely) in the specific "criminal" situation.

5. That such a study makes it possible in many cases to direct an attack upon one or more of the factors found to be active in a specific case to effect an alteration of the behavior in a propitious direction; while in other cases it is possible to foresee the probabilities in the light of past experience and discover laws to a degree sufficient to make proper provision against subsequent and further injuries to society. By the same experience and laws it is possible in still other

cases to detect and endeavor to prevent the development of potential criminality.

6. That these studies can be made effectively only by those properly qualified, *i.e.*, scientists who have made it their life interest and study to understand and treat behavior disorders.

7. That this point of view leads us to favor certain radical changes in legislative enactment and legal procedure and penal practice, incorporated in the recommendations cited below, with the idea of individual diagnosis and treatment (painful or otherwise) substituted for the idea of retributive punishment without individualization.

8. That effective preventive medicine is applicable in the field of psychiatry in the form of mental-health conferences and examinations, child clinics, mental-hygiene clinics, lectures and literature, and similar institutions and efforts.

9. That the program outlined for the scientific solution of the problems of crime should provide for:

a. The protection of society.
b. The rehabilitation of the "criminal" if possible.
c. His safe and useful disposition or detention if rehabilitation seems impossible.
d. The detection and the prevention or deflection of the development of criminality in those potentially predisposed.

The committee respectfully recommends that The American Psychiatric Association pursue the following program:

A. That the association should do the following things:

1. It should coöperate with the National Research Council, with The National Committee for Mental Hygiene, with the American Medical Association, with the American Bar Association, with the American Orthopsychiatric Association, and with the American Institute for Criminal Law and Criminology in further work on this problem.

2. It should set up, agree upon, and publish official standard qualifications of court psychiatrists and psychiatric expert writnesses, and coöperate with the American Psychological Association and the American Association of Psychiatric Social Workers in the preparation of similar official standard qualifications for psychologists and social workers attached to court psychiatric clinics.

3. It should, at its annual conventions, give more attention to psychiatry as applied to crime and other behavior disorders, including demonstrations of the practical work being done.

4. It should foster an attack on certain pressing problems of research in this field, particularly the working out of a useful nosological classification of mental disorders which will take into consideration behavior pathology not now definitely defined or classified from a psychiatric standpoint.

B. That The American Psychiatric Association should advocate:

1. Types of legislation such as the recent Massachusetts enactment and the expert-testimony bill of the American Institute for Criminal Law which put the psychiatrist in a position of counseling the legal authorities as to the disposal of social offenders, implying the development of the necessary machinery (clinics, court psychiatrists, etc.).

2. The following proposals of The American Institute for Criminal Law and Criminology with respect to trial procedure:

a. "That the disposition and treatment (including punishment) of all misdemeanants and felons—*i.e.*, the sentence imposed—be based upon a study of the individual offender by properly qualified and impartial experts coöperating with the courts."

b. "That no maximum term be set to any sentence."

3. The release of prisoners upon parole or discharge only after complete and competent psychiatric examination with findings favorable for successful rehabilitation, to which end the desirability of resident psychiatrists in all penal institutions is obvious. (Practically identical with another of the proposals of the American Institute.)

4. The permanent legal detention of the incurably inadequate, incompetent, and antisocial offenders, irrespective of the particular offense committed, and the development of the assets of this permanently custodial group to the point of maximum usefulness within the prison milieu, industrializing those amenable to supervised employment, and applying their legitimate earnings to the reimbursement of the state for their care and maintenance, to the support of their dependent relatives, and to the reimbursement of the persons injured by their criminal activities.

5. The court appointment, from a qualified list, of the psychiatrists testifying in regard to the mental status, mechanisms, or capabilities of a prisoner, with opportunity for thorough psychiatric examination using such aids as psychiatrists customarily use in practice, clinics, hospitals, etc., with obligatory written reports and remuneration from public funds.

6. The elimination of the use of the hypothetical question and the terms "insane", "insanity", and "lunacy", and the exemption of the psychiatrist from the necessity of pronouncing upon concepts of religious and legal tradition in which he has no authority or experience, such as "responsibility", "punishment", and "justice".

7. The codification of the commitment laws of the various states. "Insanity" has come to mean nothing but certifiability—*i.e.*, the social desirability of enforced hospitalization. It seems quite unnecessary to have a score of different methods for determining the basis of this step.

8. The teaching of courses in criminology in both law schools and medical schools, by persons trained in both criminal law and criminal psychiatry.

Respectfully submitted,

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APPENDIX

The nrst three sections of these recommendations are essentially identical with the recommendations of the Ninth International Prison Congress held in London in 1925. These recommendations have the merit of leaving problems in substantive criminal law to legal scholars who are, of course, the logical persons to concern themselves with such matters. The question which the congress presented itself for consideration was as follows:

"What may be done to forward the judicious application of the principle of individualization of punishment by the judge who assigns the penalty to be inflicted on the offender?"

The answers formulated and adopted by the congress were as follows:

"Before imposing any sentence or penalty, it should be an essential condition in the criminal procedure of all countries that the judge should inform himself of all the material circumstances affecting the character, antecedents, conduct, and mode of life of the offender and also any other matters which may be necessary for the purpose of properly determining the appropriate sentence or penalty", and in practice,

"a. That penal law should give the judge a choice of penalties and similar measures for prevention and security and should not strictly limit his power. It should only lay down general directions and so leave the judge free to apply the principle of individualization.

"b. The courts should be specialized as far as possible and in particular the juvenile courts should be separate from those for adults.

"c. Judicial studies should be supplemented by criminological ones. All who wish to be magistrates should be compelled to attend lectures on psychology, sociology, forensic psychiatry, and penology.

"d. The judges should devote themselves solely and permanently to criminal law and there should be sufficient opportunity for advancement in this branch.

"e. Courses of lectures should be established to complete their knowledge of criminology. They should have a full knowledge of prisons and similar institutions and should visit them frequently.

"f. The judge, before determining the penalty, should have a full knowledge of the physical and the psychic conditions and the social life of the accused and the motives for the crime.

"g. For this purpose inquiries about all his circumstances should be made before the trial. These inquiries should not be made by the police, but should be those of the magistrate himself or of persons authorized by him for this purpose, whom he should have at his disposal.

"i. If these means give no sufficient idea of the physical and psychic condition of the defendant, the judge should be allowed to have him examined by physicians and psychologists.

"j. The trial ought to be divided into two parts: in the first part the examination and decision as to his guilt should take place; in the second part the punishment should be discussed and fixed. From this part the public and the injured party should be excluded."

Announcement

The Division on Community Clinics of The National Committee for Mental Hygiene is engaged in revising and bringing up-to-date the *Directory of Psychiatric Clinics for Children in the United States*, issued by the Joint Committee on Methods of Preventing Delinquency in 1925. This directory was widely used, but is now out of print. The coöperation of all psychiatric agencies that are handling children is solicited in order that the directory may be an exhaustive and correct list of all such clinics.

The division would appreciate having the names of any clinic that was not previously listed. This would include all clinics organized after January 1, 1925.

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